UTILIZATION OF TRADITIONAL HEALTH CARE SYSTEMS BY THE NATIVE POPULATION OF SASKATOON, SASKATCHEWAN

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ABSTRACT

Little research has examined the role traditional health care systems play today among Native populations. The present research examined the role these systems play among the urban Native population of Saskatoon, Saskatchewan. The research was conducted at the Westside Community Clinic, located in the downtown core area of Saskatoon. This area of the city has previously been identified as having a high concentration of Native people. The present study represented one component of a much larger project which examined both Native and non-Native utlization patterns of the Western health care system at the Westside clinic. An interview schedule was used to gather data, with a total of 103 Native and 50 non-Native interviews being conducted. Since no sampling frame exists for the Native population of Saskatoon, an availability sampling technique was used. "Native" was defined in this study as status Indian, non-status Indian and Metis.

It was discovered that traditional health care systems play an important role in the health care of this population, with the use of these systems being quite extensive. It was determined that the variable of language was a somewhat useful predictor of the utilization of traditional health care systems, although language retention (the ability to speak a Native language) was found to be more important than the frequency with which a Native language was spoken. It was also discovered that use of traditional health care systems was not found only among older respondents, but rather was generalized among the respondents. The economic variables of income and education levels were also found to be related to utilization of traditional health care systems, with those respondents with higher income and education levels reporting greater use of these systems. Use of traditional health care systems was not found to be restricted to respondents with Indian status; rather, use was generalized among status Indian, non-status Indian and Metis respondents.

Respondents who utilized traditional health care systems also fully utilized the Western health care system. Further, use of traditional health care systems was not found to be related to difficulty respondents may have encountered in using the Western health care system, such as language or economic problems, or experiences of racism, although such problems were found to exist. Clearly, respondents did not turn to traditional health care systems because of difficulties in utilizing the Western health care

system. Rather, traditional health care systems were used to supplement the Western health care system. It was further found that the majority of the respondents in the study desired access to traditional medicines and healers within the city of Saskatoon and, again, this finding was not confined to any sub-group (i.e. older respondents) of the study but was generalized. The extent to which this access is presently available is questioned, and this could represent an important unmet health need of this population.

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I dedicate this thesis with much love
to my mum and dad.

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CHAPTER ONE: SIGNIFICANCE OF THE PROBLEM

Canadian Native people are continuing to migrate to urban centres from reserves and rural areas.[1] There is, however, a paucity of information on the health needs and health-seeking behavior of urban Natives. As Shah and Farkas have stressed, "the health issues of urban Native peoples in Canada are poorly documented,"[2] and they have called upon researchers to "determine the health problems, health needs and barriers to health care of urban Native populations."[3]

The extent to which urban Natives utilize traditional healers and traditional medicine has not been a major research concern and very little information exists. One of the few studies to examine this was a 1975 study by Fuchs and Bashshur, aimed at determining the utilization patterns of urban Natives in the San Francisco area. This study did not examine the attitudes of the subjects toward traditional health care systems, however.[4] Traditional health care systems have been acknowledged by the Department of National Health and Welfare's Medical Services Branch to still play an important role in Native health care on Canadian reserves.[5] What is not clear is whether traditional health care systems are available to

Natives living in urban centres.

Inspired by Shah and Farkas, the present research represents a sub-component of a much larger research project which examined utilization of both the Western and traditional health care systems by the Native population of Saskatoon and barriers to health care which might be preventing maximum utilization of the Western health care system.[6] The research was aimed at determining the extent of utilization of traditional health care systems and the specific components of these systems being utilized. "Native" was defined in the research as status Indian, non-status Indian, Metis and Inuit.

In undertaking this research it was felt that discovering either a high or a low level of utilization of traditional health care systems could have very significant implications for urban Native health care. Specifically, the finding that there is a high level of utilization, either in the urban or reserve context, could have two important implications. Firstly, traditional health care systems could be frequently utilized because they are still a vital part of Native cultures. This would be important for health planning for Natives because it would indicate that traditional health and health-care beliefs still prevail among urban Native people. Thus when health care programs or facilities are developed for Native people the

important role traditional health belief systems play in the contemporary Native world-view should be taken into account. Further, Western health care providers should be informed of the postive benefits of traditional health care systems for some Native patients. Clearly, if traditional health care systems are still being frequently utilized by the urban Native population, it could well be because these systems are helping to meet the cultural and/or health needs of this population.

The second implication of traditional health care systems being frequently utilized by the urban Native population could be that the Western health care system is not meeting all the needs (cultural and/or health) of Native people. Although research is limited, it appears that the urban Western health care system can pose difficulties for Native patients who have only had experience with the Western health care system in the context of a nursing station on a reserve. As well as being very complex to utilize, research indicates that the urban Western health care system presents cultural barriers to Natives in the form of communication problems between non-Native health care providers and themselves.[7] If communication problems with Western health care providers are causing Native patients to turn to traditional health care systems for some of their health needs this would have very important

implications for Native health care. For example, a traditional healer will occasionally inform his patient that "white" and "Indian" medicine cannot be combined,[8] which can lead to a patient discontinuing a prescribed medication. Clearly, a physician should know if a Native patient is also utilizing a traditional health care system. A number of Native illness etiologies, including disease-object intrusion, have existed traditionally, and the present research attempted to determine which of these, if any, are still predominant.

The alternative finding in this study could be that there is a low level of utilization of traditional health care systems. This could be the case for two major reasons. Firstly, it could be that Native patients do not feel a cultural need to seek out traditional health care systems or that the Western health care system may adequately meet their needs. In other words, the Saskatoon Native population may not desire access to traditional health care systems, which in itself would be a very important finding for Native health-care planning.

The second major reason that a low level of utilization of traditional health care systems could exist is that the Native population desires but lacks access to this system. On the reserve traditional health care systems are usually very accessible, often

with a traditional healer and medicines being available at the reserve itself or at a neighboring reserve. Medical Services will cover the transportation costs associated with travelling to another reserve for those individuals wishing to obtain treatment from a traditional healer.[9] In the urban centre traditional health care systems may become less accessible. If these systems are not available in the urban centre an individual may be forced to travel to a reserve to consult with a healer or to obtain traditional medicines. Obviously this could be an economic impossibility for some Native people because of the transportation costs involved. Further, a Native patient may wish to consult with a traditional healer but be unable to locate one if nobody in his/her family or circle of friends is aware of a practicing healer.

As was stated earlier, one of the major aims of this study was to determine if Native people in Saskatoon want access to traditional healers and medicines within the context of the Western health care system (eg. within the confines of a clinic). If the Native population of Saskatoon does not have the level of access to traditional healers that is desired, this could represent a very important unmet health need and could also have very important implications for Native health care planning. Several researchers have reported on the incorporation of traditional Native healers into

specific programs of the Western health care system, and there appears to be a recognition by some health care providers, albeit limited, that traditional healers have an important role to play in Native health care.[10]

The present research attempted to determine whether traditional healers have a role to play in promoting urban Native health care by providing the Native view of the need for their services.

CHAPTER TWO: CONCEPTUAL FRAMEWORK

The study of health care systems is complicated by the lack of consistent definitions in the classification of these systems. Kleinman has proposed three "social arenas" within a health care system: the popular (primarily the family context of sickness); folk (non-professional healing specialists); and professional (Western scientific medicine and professional indigenous healing traditions, such as the Chinese and Ayurvedic systems).[11] Press, however, has criticized Kleinman's model of a health care system, arguing that "the difference between these sectors is anything but clear."[12] Press has also maintained that Kleinman's definition of the folk arena is not definitive and suggested that the definition of "folk medicine" must be standardized within the discipline of medical anthropology.[13]

Foster has attempted to classify health care systems based upon the predominant illness etiologies within the systems. This model proposes a dichotomy between personalistic health care systems in which disease is explained as being due to the purposeful intervention of a human, non-human, or supernatural agent; and naturalistic systems, in which disease is

due to natural conditions.[14] Foulks[15] and Kleinman [16] have criticized Foster's model, arguing that both personalistic and naturalistic etiologies of illness are found within many health care systems and thus the proposed dichotomy is too simplistic. Worsley has suggested that the frequent dichotomy in medical anthropology between Western and non-Western health care systems is faulty because of the latent assumption of the superiority of the Western system.[17]

Although Worsley's criticism of the Western/non-Western dichotomy may be valid, for purposes of the present research the scientific, biomedical paradigm of health care will be referred to as the "Western health care system" as this concept is generally accepted in the literature.[18] The term "health care system" is taken from Kleinman, who defines a health care system as a cultural system which links "beliefs about disease causation, the experience of symptoms, specific patterns of illness behavior...actual therapeutic practices, and evaluations of therapeutic outcomes."[19] Practitioners within the Western health care system will be referred to as "physicians." Aboriginal North American Indian health care systems will be referred to as "traditional health care systems," and the aboriginal Indian health care practitioner will be referred to as the "traditional healer." These terms are frequently

utilized in current literature concerning North American Native populations.[20] The term "medicine man" to describe aboriginal Indian healers was rejected because it implies that these healers were traditionally and are presently predominately men when, in fact, women have played and continue to play a major role in this healing tradition within many Native societies.[21] Foster and Anderson use the term "non-Western healers" to describe indigenous health practitioners; however, this was rejected because it implies that these healers do not practice in the Western hemisphere as traditional Native healers do.[22] It must be noted here that traditional healers do not only use ancient healing methods. Rather, their philosophy of medicine and healing is compatible with beliefs and practices handed down through the generations, but the healers usually utilize some terminology and techniques from Western medicine.

The theoretical framework guiding this research is Kleinman's model of health care systems as cultural systems. In the present research, the concept of "culture" is defined as the economic, political, social, religious and medical systems of a group. Thus the medical, or health care, system of a group is one component of the group's "culture." Further, the health care system includes the totality of health beliefs and knowledge (disease etiologies), curing techniques and

practices, and societal organization for the sick. Within this model, illness and health care are seen as part of cultural systems, and the health care system of a culture "articulates illness as a cultural idiom."[23] In other words, beliefs about disease causation, illness and health care behaviour, choice of therapeutic practices and evaluations of these practices are interrelated components of a culture's health care system. However, it must emphatically be emphasized that this concept of health care systems is in no way meant to deny the very real and significant presence of structural factors, such as unemployment, poverty and racism, which can play an extremely important role in illness and health care behaviour among non-Western minority groups, such as Native populations. The criticisms of viewing health care systems as cultural systems will be addressed in the last section of this chapter.

A major component of Kleinman's model is the concept of "explanatory models" of illness. These explanatory models, which are intimately linked to one's culture, are defined by Kleinman as "notions about an episode of sickness and its treatment" which are held by all those involved in the clinical process, including health care providers, the patient, and the patient's family.[24]

Explanatory models are instrinsically tied to semantic sickness networks which represent the vehicle by which the patient articulates his/her understanding of his/her illness episode.[25] Kleinman suggests that explanatory models seek to explain the etiology, symptoms, pathophysiology and course of particular illness episodes, as well as determining the choice of treatment.[26] Explanatory models "socially produce the natural history of illness" and the natural history of illness can vary from culture to culture. The idiom of expression of illness is culturally variable; the health care interaction is not an objective experience but is successful only insofar as the physician is able to decode the patient's semantic sickness network.[27] Thus problems in communication can arise between physicians and patients of different cultures. In the case of the present research, a Native patient who holds traditional health beliefs may have an explanatory model very different to that held by his/her physician. Kleinman's model of health care systems as cultural systems is applicable to the study of communication problems which can affect the clinical encounter between a Western physician and a Native patient.

Kleinman has argued that a model of health care as a cultural system should "operationalize the concept of culture in the health domain."[28] It is hoped that

the following hypotheses do this. The hypotheses to be tested in the research are as follows:

1. Socio-cultural variables will be significantly more important than socio-economic variables in prediciting utilization of traditional health care systems by Native respondents.

This hypothesis is based on the assumption that those respondents who have closer ties to their culture will be more likely to utilize traditional health care systems. The socio-cultural and socio-economic variables are outlined in section 5.5.1.

2. Those respondents with Indian status will be significantly more likely than those without Indian status to utilize traditional health care systems.

This hypothesis assumes that respondents with Indian status, because of their legal affiliation with a reserve, would have greater knowledge of and access to traditional health care systems and thus be more likely to utilize these systems.

3. Respondents who have experienced difficulty utilizing the Western health care system will be significantly more likely to utilize traditional health care systems than respondents who have not experienced this difficulty.

This hypothesis is derived from Fuchs and Bashshur's finding that Indian families who experienced difficulties utilizing the Western health care system utilized traditional medicine to a greater extent than families not experiencing this difficulty. [29]

4. Respondents who are more "traditional" will be significantly more likely than "non-traditional" respondents to desire urban access to traditional health care systems.

Again, this hypothesis assumes that respondents who have closer ties to their culture, that is who are more "traditional," will be more likely to utilize traditional health care systems and thus would be more likely to desire access to these systems within the city. "Traditionality" was measured through a number of socio-cultural variables which are outlined in section 5.5.4.

Kleinman's model of health care systems as cultural systems has been criticized by Young who has argued that the concept of explanatory models suffers from the same flaw as the biomedical model of medicine: namely, the individual is the focus of study. Young further argues that explanatory models are faulty in that they do not analyze the power relations within the Western health care system and the power relations which exist between social groups and classes.[30]

Frankenberg has similarly argued that the study of health care systems must be within the context of analyses which examine the process by which the capitalist mode of production comes to dominate precapitalist forms of production, and the role this process plays in determining health and health care behaviour.[31] Navarro[32] and Baer et al.[33] have emphasized the role power relations play within a society, shaping social processes such as research in disciplines including medical anthropology and the medical research establishment. Navarro has stressed the bias of the medical research establishment in its focus on the individual causation of disease rather than the social factors which can play a major role in disease causation.[34]

The model of health care systems as cultural systems is not meant to invalidate the fact that health care systems are also social systems. Kleinman has stressed that "to divorce the cultural system from the social system aspects of health care in society is clearly untenable."[35] As Baer et al. have pointed out, the decision-making bodies of the health institutions of the Western health care system are comprised of members of the Anglo middle and upper classes.[36] It can logically be surmised, then, that the Western health care system is not organized so as to reflect the cultural needs of minority populations, but rather to

reflect the needs of the dominant society. This is one reason why a cultural analysis is appropriate in the present research; the determination can be made whether the cultural needs of the Native population are being met in the Western health care experience. A cultural analysis of the health care experience was also chosen because the present research is essentially a micro-analysis of a specific urban Native population with an aim of providing practical recommendations in terms of enhancing or improving the health care experience of this population. If the present research had taken as its research population the Canadian Native population, then a macro-analysis would have been appropriate. A cultural analysis was also employed in the present research because, as was mentioned in Chapter One, this research project is one component of a much larger project which is examining utilization of both the Western and traditional health care systems by the Native population and is also attempting to determine if structural and/or cultural barriers are preventing optimum utilization of the Western health care system. Thus structural factors, such as poverty, unemployment and racism, will be analysed within this same research population.

In presenting the conceptual framework for the present research it must be emphasized, once again, that the concept of health care systems as cultural

systems is not an attempt to deny the existence of structural factors and their significant role in the health care behaviour of the Native population. Rather, the reality of these structural factors is accepted, but it is felt that within the confines of these structural realities researchers can work to understand the health care experience of a cultural minority group and strive to make concrete proposals which would improve the health care experience of this group.

CHAPTER THREE: REVIEW OF THE LITERATURE

3.1 Urban Native Health Research

The first major area of research concerning urban Native populations examined the transition these populations underwent moving from reservations to urban centres. These studies of urban adjustment appeared largely in the 1960s and had as their focus of study American Native populations.[37] A similar study was conducted in 1967 in an unspecified Saskatchewan urban centre by Gold who concluded that urban Indian respondents who were "acculturated" followed a "deferred gratification pattern" (eg. saving money for the future) rather than the typical pattern of "immediate gratification" found among "unacculturated" reserve Indians.[38]

In the 1970s, the focus of investigation shifted from examining urban adjustment to examining the utilization of health care facilities by urban, largely American Native populations, and the socio-economic barriers which were preventing maximum utilization of the Western health care system by these populations.[39] In a 1974 study, Fuchs found that the urban Native population of San Francisco under-utilized medical services in terms of the annual number of

physician visits and concluded that a main barrier to utilization was economic, such as an inability to afford transportation and medical bills.[40]

A number of studies and books on Canadian urban Native populations also appeared in the 1970s; however, few of these studies examined the utilization of the Western health care system or the health needs of these populations. In 1974, Price[41] and Frideres[42] examined the urban integration of Natives in Canada and the problems they encountered but did not deal with health care. A 1970 study of skid row Indians in Toronto by Nagler did provide a discussion of the problems created by alcohol among this population,[43] and Stanbury's 1975 book Success and Failure: Indians in Urban Society included a chapter on the health of urban Indians in British Columbia. Stanbury discovered a positive relationship between the average yearly visits to a physician and level of education, and he also found a higher hospitalization rate among the Indian population compared to the non-Indian population of British Columbia. [44] In a 1981 study, Clatworthy and Gunn determined that 62.8% of urban status Indians in British Columbia lived below the poverty line and 78.9% of status Indians in Winnipeg received social assistance, but failed to discuss health issues.[45]

Several studies and books have discussed the Native population of Saskatoon. Davis noted in 1962 the

increasing migration of Metis and Indians from Northern Saskatchewan to urban centres such as Saskatoon.[46] Dosman's 1972 book Indians: The Urban Dilemma also provided a study of the Native population of Saskatoon. Little reference was made to the utilization of health services by this population; however, Dosman did note that in 1967 the Saskatoon Indian Committee formed to press Indian Affairs to continue to cover medical and dental expenses in the urban centre. The committee was concerned that Indian Affairs did not feel it was bound by the court decision which interpreted the Medicine Chest clause of Treaty Six as meaning that Indians were entitled to free medicines and medical care (a decision which was subsequently overturned).[47]

Another book which examined the urbanization of Indians in an unspecified prairie city was Brody's 1971 Indians on Skid Row, which concentrated on alcohol problems among a skid row Indian population.[48] In 1983, Clatworthy and Hull provided a study of the socio-economic conditions of the Native populations of Regina and Saskatoon. They determined that the majority of the Native populations in both these centres lived at or below the poverty line.[49] The 1979 Report of the Task Force in Housing for Native People in Saskatoon concluded that the majority of the Native population lived in substandard housing, concentrated largely in

the older core neighborhoods west of downtown Saskatoon.[50]

In the 1980s, research on the health status and health care behavior of Canadian urban populations began to appear. In 1981, Mears et al. investigated the health problems and illness treatment strategies of the skid row Native population in Vancouver.[51] A 1984 study by the Social Services Department of the City of Calgary determined that the majority of Native people in the city faced no difficulties in obtaining health care, although the study did suggest that Native men under-utilized health care services.[52] Similarly, a 1985 study by the Native Counselling Services of Alberta and Native Affairs Secretariat concluded that 91% of Native people in Edmonton did not experience any difficulties in obtaining health care.[53] In a 1985 article, Shah and Farkas provided a discussion on the health problems, health needs, and barriers to health care of the Canadian urban population in general.[54] In 1986, Farkas and Shah examined the extent to which public health departments in major Canadian urban centres had conducted research on the health status and health needs of the local Native population, and whether any health services or education programs had been developed for this population. The researchers found very little action in these areas.[55] A 1982 report by Matthews and Hart, which was prepared for the

Joint Saskatoon Hospital Planning Group, provided a discussion of the barriers to health care and health needs of the Saskatoon Native population.[56] A 1986 study by Layman investigated the health needs of the Saskatoon Native population, as perceived by both Native and non-Native health care providers, and also examined whether any health-related programs had been developed for the Native population in Saskatoon.[57]

In conclusion, it is clear that research on the health needs and health care behaviour of urban Canadian Native populations is still very limited although this is a research area which is increasingly being investigated. It is hoped that the present research will be an important addition to this body of literature.

3.2 Contemporary Native Health Issues

It has been argued that many of the health problems suffered by the Native population are a reflection of stresses brought on by severe economic deprivation.[58] One of the most serious manifestations of these stresses is the extraordinarily high accidental and violent death rate of this population, which often involves alcohol and/or drug abuse. Accidental and violent deaths, which include deaths due to motor vehicle accidents, drownings, exposure, fire,

falls, overdoses, poisonings, homicides and suicides, have steadily increased in the past two decades.[59] Within the confines of a national society which is unable or, more likely, unwilling to alter the socio-economic status of the Native population, perhaps positive steps can be taken to alleviate the symptoms of this problem. It could be that traditional health care systems have an important, and as yet largely unexplored, role to play in combating these types of deaths among the Native population. Traditional Native treatment modalities, such as the sweat lodge, the peyote ritual and the Spirit Dance, appear to be successful in the treatment of alcohol and drug abuse among Native populations.

3.2.1. Accidental and Violent Deaths

Several researchers have analyzed the accidental and violent death rate among the national American Indian population, determining that the suicide and homicide rates were higher than those of the non-Indian American population,[60] and that Indian children had an accident mortality rate which was three times that of non-Indian American children.[61]

Researchers have also examined accidental and violent deaths among specific American Indian populations. Many studies have examined the Navajo [62] and Papago Indians,[63] concluding that the accidental

and violent death rate among these populations was much higher than that of the non-Indian American population. Other American Indian populations have been examined, again with the determination that the accidental and violent death rates exceeded that of the non-Indian American population.[64]

Several Canadian governmental reports have discussed the severity of the national Indian accidental and violent death rate in comparison to the national non-Indian population. In 1979, Siggner reported that the leading cause of death among the combined Indian and Inuit population was accidents/violence/poisonings (ranked third among the non-Indian population), and that the Indian suicide rate was two times that of the non-Indian rate.[65] A 1980 report by the Department of Indian Affairs and Northern Development also recognized the vast differences in the causes of death between the Indian and non-Indian populations of Canada, noting that the leading cause of death among the Indian population was accidents, while diseases of the circulatory system ranked first among the non-Indian population.[66]

Several Canadian studies have also investigated the problem of accidental and violent deaths among specific Indian populations. Schmitt et al. found that accidents were the leading cause of death among the registered Indian population of British Columbia from

1959-1963, but ranked only fourth among the non-Indian population.[67] Hislop et al. also investigated accidental and violent deaths among the registered Indian population of British Columbia for the years 1953-1978 and discovered a significant difference between the death rate for Native males compared to non-Native males for accidents, homicides, and suicides. Similarly, significant differences were found to exist between Native and non-Native females in terms of the death rates for accidents, homicides, and suicides.[68]

A major study was carried out by the Grand Council Treaty 3 in 1974 on sudden deaths among the Indian population of the Kenora area. This study is significant in that it was one of the first such studies conducted by an Indian organization. The Council discovered that 75% of all Indian sudden deaths were accidents, with the most common type of accident being drowning (22% of all accidents). In addition, the Council found that 20% of sudden deaths were the result of firearms, hangings and stabbings, 19% were suicides, and 8% were motor vehicle accidents. It was also discovered that Indian males were at a greater risk of dying an accidental or violent death (66.6% of males died an accidental or violent death) compared to Indian females (33.3%). Further, the Council found differences between the sexes on the most common type of accident:

males were more likely to die from drowning, while the number one ranked female accident was exposure. Finally, the Council concluded that alcohol played an extremely important role in the sudden deaths of Indians.[69]

T. Kue Young analyzed the Indian mortality data of the Sioux Lookout Zone of north-western Ontario and found that from 1972-1981 injuries and poisonings constituted the number one ranked cause of death, compared to number three in the national Canadian population.[70] Ward and Fox have also reported a series of eight suicides by young adults on a northern Ontario reserve in 1974.[71] This is similar to the situation in Cross Lake, Manitoba where in the first five months of 1987 eight youths aged 10-18 committed suicide.[72]

In 1982, Jarvis and Boldt reported on their major study of Native (Indian and Metis) mortality in Alberta which determined that: "Natives encounter death under very different circumstances and from different causes than do Canadians and the style of death reflects a style of life that is different from that of the general population."[73] The different circumstances Natives encounter include the finding that Natives die younger than non-Natives and die in clusters of two or more people (52% died in the company of other Natives). Further, it was found that 60% of Natives die outside of hospitals, and 25% of these deaths were in the

company of nine or more other Native people. According to Jarvis and Boldt, the death of a Native is a "social event." Jarvis and Boldt also discussed the different causes of death between the Native and non-Native populations: 32.4% of Native deaths were accidental compared to 8.6% for the non-Native population; and 3.5% of Native deaths were from homicide, compared to 0.6% for the non-Native population. The researchers make two major conclusions about Native mortality: firstly, that alcohol plays an extremely important role; secondly, that the special life circumstances of Natives, namely their low socioeconomic position, makes them vulnerable to accidents.[74] In March of 1986 the Cree Indian settlement of Peerless Lake in Alberta received national attention when five people at a party died from drinking duplicating machine fluid.[75] This settlement, which suffers from rampant unemployment, likely created the "special life circumstances" referred to by Jarvis and Boldt.

Several recent studies have looked at mortality patterns on Canadian Indian reserves. In 1986 Mao et al. reported that the violent death rate among the reserve Indian population was three to four times higher compared to that of the Canadian non-Indian rate. They also found the age-specific suicide rates of Indian males and females to be significantly higher than the non-Indian population (Indian male =

53/100,000, non-Indian male = 19.9/100,000; Indian female = 17/100,000, non-Indian female = 6.4/100,000).[76] In a 1986 analysis of mortality data for Indian reserves, Morrison et al. reported a significantly higher rate of infant deaths due to fires than that found among the non-Indian population.[77] Similarly, in 1982 Evers and Rand found a significantly higher rate of injury-related morbidity among Canadian Indian children compared to non-Indian children in their first[78] and second year[79] of life.

The Saskatchewan status Indian population has a much higher accidental and violent death rate compared to the non-Indian population (it is necessary here to speak strictly of the status Indian population because vital statistics are only compiled for this population). Accidents and violent deaths were the leading cause of death among the status Indian population from 1972 to 1984, but were never above a number three ranking in the non-Indian population. In 1984 there was still a large discrepancy between the two populations, with the status Indian rate being 2.6 times that of the non-Indian rate (Indian rate = 173.5/100,000; non-Indian = 65.2/100,000). It is alarming that from 1972 to 1984 the percentage of status Indian deaths from accidents or violence was never below 36%, and in 1984 this figure reached 37.5%, meaning that over one-third of all status Indian deaths

were accidental or violent. In contrast, the highest percentage of accidental and violent deaths among the Saskatchewan non-Indian population was 10.05% in 1981.[80]

The percentage of accidental and violent deaths among the Saskatchewan status Indian population saw a generally steady and significant increase from 1960 to 1984. In 1960, 10% of all status Indian deaths were from accidental or violent causes; but by 1984, 37.5% of status Indian deaths were accidental or violent. Throughout the mid-twentieth century infectious and parasitic diseases (largely pneumonia) were the leading cause of death among the status Indian population, and accidents and violence ranked number two. In 1965, accidents and violence became established as the leading cause of death among the status Indian population (170/100,000) and remained as the number one ranked cause of death to 1984.[81] In the 1984-85 period the second ranked cause of morbidity/ mortality among Native patients at St. Paul's Hospital, Saskatoon was found to be injuries and poisonings.[82]

The status Indian population of Saskatchewan has a much higher suicide mortality rate compared to the non-Indian population. In 1984 the status Indian rate was 40.6/100,000, while the non-Indian rate was 13.2/100,000. Further, there is a very sharp increase in the suicide rate of the male status Indian

population in the age group of 15-24 years, which reached an alarming 117.5/100,000 in 1984 compared to 37/100,000 among the Saskatchewan non-Indian male population of the same age group.[83] A recent study by the Saskatchewan Alcohol and Drug Abuse Commission found that alcohol and drug abuse were involved in a 75% of Native suicides as compared to 64% of non-Native suicides.[84]

A study by the Federation of Saskatchewan Indian Nations compared Saskatchewan status Indian accidental and violent deaths by health zone from the years 1981-1983. The study revealed that motor vehicle accidents were the most frequent type of accidental/violent death in all the health zones. The North Battleford zone had the highest motor vehicle death rate at 94.5/100,000 which was over two times the rate of the other zones. The second most frequent type of accidental/violent death was in the "other" category which includes deaths by assault, suffocation, and homicide. The Prince Albert zone accounted for 50% of all deaths in the "other" category in the province with a rate of 43/100,000. The researchers esimated that approximately 62% of all deaths in the "other" category are alcohol, drug or substance-abuse related.[85]

As Moffatt has pointed out, in any discussion of Native accidental and violent deaths it is important to remember that there is a "tremendous variation" in the

suicide rates across Indian communities, with some areas having rates which parallel those of the general Canadian non-Native population.[86] However, it is clear that a serious problem exists and steps must be taken to begin to ameliorate the situation.

3.2.2. Alcoholism and Drug Abuse

An issue which is closely tied to the discussion of accidental and violent deaths among the Native population is alcohol and drug abuse. A wide body of literature has sought to explain Native alcoholism in terms of analyses of the role played by acculturative stress. Researchers have examined both American [87] and Canadian[88] Indian populations, concluding that the stress these groups faced was the causative factor in their alcoholism.

Numerous studies have attempted to determine the prevalence of Native alcohol and drug abuse. The high alcohol and drug use rate among American Indian adolescents[89] and adults[90] has been described. Little information exists on the prevalence of alcohol and drug abuse among Canadian Native populations. However, a 1984 study on alcohol and drug abuse by the Federation of Saskatchewan Indian Nations provided some important information. The research involved a survey of almost nine hundred adults on twelve reserves and four hundred adolescents on eleven reserves. It was

determined that between 35 and 40% of the adult Saskatchewan status Indian population and 10 to 15% of the adolescent population (15-19 years) had an alcohol abuse problem, and 20-25% of the adult and 5 to 10% of the adolescent population had a drug abuse problem.[91]

Several studies have also examined the prevalence of alcohol and drug abuse by urban Native populations in Chicago,[92] Minnesota,[93] and Sioux City,[94] with researchers commenting upon the high degree of alcoholism among these populations.

The paramount role of alcohol has often been emphasized in studies of Native accidental and violent deaths and some prevalence data for Canadian Native populations have been produced. In 1966, Schmitt et al. discovered that alcohol was a contributing factor in 28% of all accidental deaths among the Indian population of British Columbia.[95] In 1969, the Standing Committee on Indian Affairs and Northern Development noted the significant role alcohol was playing in Canadian Indian accidental and violent deaths.[96] In 1973 The Grand Council Treaty 3 determined that 73% of all accidental deaths among the Indian population of Kenora, Ontario involved alcohol. Further, categorization of the accidental deaths by blood alcohol level revealed that 11% of the alcohol-related accidental deaths had a "heavy" level of intoxication (defined as .16 to .23% blood alcohol, or "staggering

drunk"; legal limit is .08% blood alcohol). Alcohol-related acccidental deaths in the blood alcohol category of "very heavy" (.24 to .34% blood alcohol, or the "pass-out stage") stood at 21%; and such deaths stood at 7% in the blood alcohol category of "extreme"(.35% blood alcohol, or the "comatose" stage). The Council also discovered that Indian males died from alcohol-related accidents almost two times more than Indian females (males=46.5%; females=24.8%).[97] In 1982, Jarvis and Boldt reported in a study of Native accidental and violent deaths in Alberta that alcohol was directly involved in over 40% of these deaths.[98]

It is very difficult to make any generalizations about the extent of alcohol and drug abuse among Native populations based upon the prevalence studies cited. Most of the studies do not provide adequate data on the prevalence of this abuse and when data is provided it usually reflects a small population, making generalizations about the entire Native population difficult. Heindenreich has made a very good point in arguing that not enough substantial comparisons of alcohol and drug abuse between tribal-geographical groups have been done, and he has suggested that significant differences in abuse patterns exist between Natives communities.[99] Thus while it is not always appropriate to make generalizations about the entire Native population in regard to accidental and violent

deaths and alcohol/drug abuse, a serious situation does exist. The role of traditional Native treatment modalities in alleviating alcohol and drug abuse, and thus possibly lessening the occurance of accidental and violent deaths, will be discussed in section 3.4.

3.3 The Western Health Care System

3.3.1 Utilization by the Native Population

In 1969 a study on health services for Canadian Indians done for the Canadian government concluded that:

> Many Indians exhibit little awareness of what is meant by good health and they tend to both over-utilize and under-utilize health care resources. Medical care is often sought for minor problems... on the other hand, Indians frequently fail to recognize significant symptoms and delay seeking treatment until they are acutely ill.[100]

The researchers employed a "blame the victim" ideology, suggesting that the difficulties Indian people face in utilizing the health care system are the result of their inability to properly understand how it is to be utilized. Subsequent research has recognized, however, that barriers are often in place which prevent maximum utilization of the Western health care system by Native people. Clearly, the socio-economic status of the Native population acts as a major barrier to health care. Also very important to understanding the

utilization patterns of the Native population is the population's knowledge of the Western health care system. This can be particularly significant in the urban context. Kirchner reported that minority groups seeking health care in city clinics may face problems in utilizing services because of their unfamiliarity with the Western health care system.[101]

On the reserve the Western medical system is usually represented by the nursing station or similar facility. The nursing station, and thus the Western health care system, is very accessible and many of an individual's primary health needs can be met by this single facility, either through resident nursing staff or through the physicians, dentists and other health care professionals who provide services to reserves. In the urban centre a Native individual is faced with a very complex Western health care system in which one must utilize various subcomponents (eg. clinics, hospitals, dental offices) to have one's primary health needs met.

Research on the utilization of the Western health care system by Native populations, although limited, indicates that the complexity of this system in the urban centre can be a factor preventing maximum utilization. Fuchs discovered that a major reason for the under-utilization of medical services by Natives in San Francisco was that they did not know where to go

for services.[102] Similarly, Miller's study of an Indian free clinic in Los Angeles revealed that one of the most significant barriers to health care was a lack of a clear understanding of the clinic's procedures and who to contact within the clinic for health care.[103]

A 1982 position paper by the Joint Saskatoon Hospital Planning Group argued that Native people migrating to Saskatoon have problems utilizing the Western health care system because of the difficulties in following directions by health care providers, often given rapidly in English, and because of difficulties in keeping scheduled appointments.[104] Nemetz has also argued that the health of urban Canadian Natives is jeopardized by their lack of familiarity with the urban Western health care system.[105] Shah and Farkas have pointed out that status Indians migrating to urban centres may not realize that their medical coverage shifts from a federal to a provincial responsibility and thus may not have adequate coverage in the urban centre.[106] Thus the urban Western health care system can be particularly difficult to utilize for Natives coming from reserves or rural area.

In a major 1979 study, McCaskill reported that Native people in major Canadian urban centres (Toronto, Vancouver, Edmonton and Winnipeg) were generally satisfied with the health care services they received.[107] Similarly, several studies in the 1980s

have also investigated the health care utilization patterns of urban Natives. Studies in Calgary[108] and Edmonton[109] concluded that Natives in these centres did not face any significant barriers in obtaining health care. A 1988 study by Waldram and Layman determined that while the Native population of Saskatoon did face some barriers in utilizing the Western health care system, a high level of utilization was occurring.[110]

One specific area of concern identified by some researchers is the under-utilization of prenatal health care services by Canadian Native women. In 1967, Graham-Cumming suggested that while pregnant Canadian Indian women were increasingly using prenatal services, only approximately 30% were currently making adequate use of these services.[111] This problem has also been identified by American researchers. For example, in 1970 Littman reported that many pregnant Indian women did not fully utilize prenatal medical services in Chicago, which resulted in many of these women being seriously undernourished.[112] Similarly, a 1984 Native Needs Assessment determined that Native women in Calgary did not utilize prenatal medical services or well-baby clinics extensively, with 25% of these women receiving no prenatal services.[113] In a recent article, Glor reported that few Native women in Regina attended pre-natal classes, but a prenatal program begun under the auspices of the Regina Native Women's Association

resulted in a significant increase in the number of Native women attending these classes.[114] The Westside Community Clinic in Saskatoon provides a "Healthy Moms-Healthy Babes" program, with three Native health workers.[115]

A great deal of research has been concerned with determining the extent to which particular groups in North America utilize the mental health care system, as well as evaluating the quality of the psychotherapeutic services received by these groups. Some of the first studies to examine utilization of the mental health care system focused upon the relationship between one's socio-economic class and utilization patterns, and generally concluded that patients from lower socio-economic classes received a lower quality of mental health care compared to patients from upper socio-economic classes.[116] Another major area of research focused upon the utilization of mental health care services by minority groups, again concluding that these groups have lower utilization rates and received lower quality mental health care services compared to Caucasian patients.[117]

Researchers have also focused upon the utilization of the mental health care system by Native North American populations, although not to as great an extent. In 1974, Barter and Barter described the urban Indian as being "invisible" to mental health agencies

and found a low level of utilization of mental health services by urban Indian populations in California.[118] In 1978, Sue et al. examined the psychotherapeutic services received by Chicano and Native Americans in seventeen community mental health clinics in the Seattle area and found that Natives were over-represented in the centres but failed to return for treatment in 55% of the cases.[119] In another 1978 study, Borunda found that Indians in Portland had a low level of utilization of mental health services.[120] In a 1980 study of minority utilization of over two hundred American community mental health centres, Wu and Windle discovered that Natives had a low level of utilization and also that few of these centres had Native professional staff. The researchers suggested that increasing minority staffing in these centres would increase minority utilization.[121] In a 1980 study, Rhoades et al. examined the prevalence rates of utilization of mental health services by Native Americans and discovered a rate of 235.1/100,000 among the 45 to 49 age group, representing nearly one consultation with mental health services for every four Indian people.[122]

Information on the utilization of mental health services by Canadian Native populations is very sparse. In a 1972 study, Hendrie and Hanson discovered that Indian and Metis patients at the Winnipeg Psychiatric

Institute received significantly fewer follow-up appointments and had shorter hospital stays compared to non-Native patients. The researchers suggested that this was related to the staff's attitudes on the benefits of psychotherapy for minority patients.[123] In an examination of Indian rates of public sector outpatient psychiatric treatment services in Saskatchewan, Fritz and D'Arcy found that the Indian population received at least 40% fewer outpatient services per capita than the non-Indian population.[124] Because there is a dearth of information on the utilization of health and mental health services by Native populations it is difficult to develop an accurate understanding of the utilization patterns of these populations. However, it does appear that the Native population faces real problems in utilizing the Western health care system, as will be discussed in the following section.

3.3.2 Socio-Cultural Barriers Facing the Native Population

As well as being very complex to utilize, research indicates that the urban Western health care system presents cultural barriers to Natives in the form of communication problems with non-Native health care providers. In an early article, Kadushin commented upon the strict social distance which is maintained between

physicians and patients,[125] which can likely be expected to magnify when the patient is Native. In a 1984 study of the interaction between Cree and Ojibwa clients and non-Native nutrition educators, Farkas observed that while probing and direct questions are considered appropriate etiquette within Euro-American communication patterns, they are not considered appropriate in Ojibwa or Cree. Further, within Ojibwa and Cree communication etiquette a reply is not obligatory.[126] Shah and Farkas also noted the emphasis placed upon barriers in communication between Native and non-Native health care providers by an 1981 Ontario Task Force on Native People in Urban Settings. The Task Force also reported that social service staff recognized that problems in communication existed between themselves and their Native clientele.[127] A 1981 study of the health status and health needs of Vancouver's skid row Native population by Mears et al. discovered that health care providers were not well informed about the health problems of Natives and were conscious of the fact that the clinical relationship between themselves and their Native clientele was poor.[128] A 1986 survey of Canadian public health departments by Farkas and Shah discovered that most city public health departments have no data on the health needs of the local Native population and no

specific public health programs had been developed for this population.[129]

Layman's 1986 study on the status of Native health care in Saskatoon determined that health care providers, both Native and non-Native, believed that communication problems existed between some health care providers and Native patients.[130] A 1982 position paper on Native health care in Saskatoon by Matthews and Hart stressed the role cultural barriers play in the utilization of the Western health care system by this population.[131] Out of this position paper grew a specific proposal for a Native health liaison project in Saskatoon. This proposal stressed that the "unique health needs of Native people have been overlooked," and that while increased health care services for Natives must be provided it can not be at the expense of ignoring the cultural philosophy of Native people. One of the main points of the proposal was that giving Native people who are not fluent in English the opportunity to receive health care in their own language through the use of Native health liaison workers would preserve the dignity of Native patients and allow health care to take place in a manner which is consistent with Native culture.[132]

Kleinman[133] and Good and Good[134] have stressed the role that different explanatory models of illness can play in preventing maximum utilization of the Western

health care system by non-Western patients. For example, a Native patient may employ an explanatory model for a specific illness episode with the etiology of disease-object intrusion, or more generally a form of "bad medicine." This patient may or may not exhibit physical symptoms with this illness, such as contortions or swelling of the face and limbs. A Western physician may be unable to successfully treat such an illness if in the patient's mind he/she is the victim of the evil machinations of another individual, usually an enemy, evil shaman or witch. Since a physician's explanatory models are derived ultimately from the biomedical model of medicine, the physician does not normally recognize illness due to supernatural causes. The Native patient may leave the clinical encounter feeling that he/she has not been adequately treated, believing that until the evil causing the illness is counteracted through the medicine of a powerful healer he/she will remain ill. A traditional healer may then be consulted who may effect a cure.

Mental health programs for Natives have also been criticized as being culturally insensitive.[135] Bittker has stresssed that mental health programs for the urban American Native population are inadequate, and he has described this population as being "conspiciously ignored" by contemporary mental health service delivery systems.[136] Shah and Farkas have suggested that the

data on the mental health needs and utilization patterns of the urban Canadian Native population are "minimal," and that there is an urgent need for more research in this area.[137] The researchers have argued that it is clear that the mental health needs of urban Natives are not being met and there is evidence of a high prevalence of solvent sniffing, suicide, depression, and family crises among this population.[138] In their review, Farkas and Shah noted that the Native population was identified by public health departments as suffering mental health problems associated with poverty, unemployment, and adjustment to urban life.[139] One of the major barriers identified by Farkas and Shah as preventing the urban Native population from utilizing mental health services were cultural differences between this population and mental health care providers.[140] Carlson [141] and Barter and Barter[142] have also commented upon the difficulties encountered by Natives seeking counselling due to language barriers between the Native clientele and the counsellors.

A 1978 Task Force on the Mental Health of Canadian Natives suggested that while Native people suffer "more than their fair share of what can be termed the negative indices of mental ill health," there are few Native people involved in the delivery of mental health services to Natives.[143] According to the task force, many human services for Natives are in the hands of

non-Natives who do not understand or empathize with the culture or world-view of Natives. The task force concluded that Natives lack control over their lives, and in order to obtain some control, Native human services, including mental health services, must be turned over to Native people.[144] Similarly, a 1983 task force suggested that the mental health services available to Native people often undermine Native culture and history, and assimilation is often a prerequiste to receiving adequate mental health care.[145]

In a comparison of the Western psychiatrist and the Native patient, Jilek-Aall argued that there are several important differences which can hinder effective psychotherapy. For example, while the psychiatrist sees physical and mental illnesses as distinct entities, the Native patient may not make such a distinction; also, the psychiatrist sees disease as primarily a phenomenon of nature, while the Native patient may see it as a phenomenon of the supernatural. According to Jilek-Aall, an effective psychotherapist must be able to distinguish between genuine psychiatric illness and culturally-determined mental illness, and must recognize when a traditional Native healer would be of more benefit to a Native patient than Western therapies.[146] Likewise, Duran has argued that Western psychotherapists must alter the role they play when

treating Native patients and should assume a more active and "knowing" role rather than their usual passive role. Thus the psychotherapist would play a role more like that of a shaman, who informs the patient as to the cause and treatment of his/her illness.[147]

Clearly, Native patients face cultural barriers when utilizing the Western health care system. Health care providers can be insensitive and often are simply uneducated as to the needs and beliefs of their Native clientele. The following chapter will explore traditional Native health and health care belief systems.

3.4 Traditional Health Care Systems: Disease Etiologies and Treatment Modalities

No single source exists which has extensively examined traditional North American health care systems; rather, only scattered references to traditional Native healers, traditional disease etiologies, and traditional treatment modalities exist. It is felt that if one is going to attempt to discuss traditional health care systems in any meaningful manner a discussion of these systems, and particularly the role of the healer (traditionally the shaman) and traditional disease etiolgies and treatment modalities is necessary. A cross-cultural survey of Native traditional health care systems is provided in order to

demonstrate the cultural variability of these systems within North America. This is also felt to be very important in order to provide a complete discussion of traditional health care systems and to dispel the often held conception that there exists one traditional health care system in North America which contains homogeneous elements in all geographic locations. In fact, traditional health care systems are often unique and to agglomerate them all into one category is to do them a great disservice.

The following chapter represents an amalgamation of a wide range of sources on traditional Native health care systems, including medical, psychiatric and anthropological journals, as well as numerous books and classic ethnographic and ethnological monographs. It is often assumed even today that traditional health care systems are simplistic and represent superstitions from which peoples must be liberated. Similarly, traditional healers are at times referred to pejoratively as "witch doctors" who are felt to be clearly inferior to physicians trained within the Western health care system. This is especially disconcerting when such beliefs are held by Western health care providers. It is hoped that the following discussion adequately conveys both the complexity and sophistication of traditional Native health care systems, as well as the great diversity of these systems from cultural group to

group. Whenever possible, emphasis will be placed upon cultural groups found in Saskatchewan, including Cree, Saulteaux, Dakota and Dene groups.

3.4.1 The Shaman

The central figure in aboriginal North American healing traditions is the shaman, often referred to today as a traditional healer or medicine man/woman. Grim has noted that the origin of the term "shaman" is from the Tungusic words saman or hamman, which as nouns mean "one who is excited, moved or raised," and as verbs means "to know in an ecstatic manner."[148] According to Halifax, the origins of shamanism are found in the Palaeolithic period when shamans came to be linked to the animal world of the hunt and eventually became metaphysically identified with animals as they sought to become their master and control their actions.[149] Johnson has suggested that the Micmac believed that long ago everyone was a shaman and performed acts which benefited all the people.[150]

The shaman usually acquired his curing power through forcible "election" by the supernatural. This election could occur during an unsolicited dream or visitation by the supernatural, or during the vision quest when the supernatural informed the chosen individual that he is to be a shaman. Election was often characterized by serious illness, especially in

the classic Siberian shamanism, and during the recovery period the secrets of curing were revealed.[151] Grim has characterized the development of a shaman as occurring in three stages: firstly, the call from the supernatural; secondly, sickness and withdrawl during which the initiate suffered both psychic and physical illness; thirdly, emergence in which the initiate came out of his dark period of illness, having suffered the call from the spirits, and emerged as an integrated healer.[152] Halifax has characterized the evolution of a shaman as occurring through the crisis of death and re-birth in which a profane individual was transformed into one who is sacred. Through dreams and visions the rules of the higher order are made known and the purely sacred is obtained by the shaman initiate.[153]

Benedict has noted that among Western Plains tribes there was an absence of a laity-shaman distinction, for it was obligatory for all young men to go on a vision quest to obtain power at least once in their life.[154] Mandelbaum has discussed the vision quest among the Plains Cree, during which young boys fasted and prayed for several days and nights until their spirit helper appeared. When the spirit helper appeared it identified itself and led the boy to a great tipi where there was an assemblage of spirit powers who were in human form. The boy was then told of the gifts he had been granted and often was informed of

a special ability granted him, such as the ability to construct a buffalo pound, conduct a ceremony such as the Sun Dance, or to heal the ill. The spirit helper could impose a food taboo, such as against eating dog meat, upon the boy. Upon awakening the boy returned to his camp but did not immediately relate his vision to others. Often the vision quest was repeated because of instructions in the original vision or because the individual wished to secure additional power. Mandelbaum has concluded that among the Plains Cree many individuals had supernatural power bestowed upon them; thus shamanism was practiced by many in varying forms and to varying degrees.[155]

A strict laity-shaman distinction was also absent among the Assiniboine, according to Lowie.[156] Similar to the Plains Cree, tribesmen went out on vision quests and, depending upon the nature of their communication with supernatural powers, they could become a shaman, a root doctor, a prophet, or the founder of a dancing society. Thus, concluded Lowie, the religious experiences of the shaman and laity were fundamentally the same, with the only difference being the extent or degree of the experience.[157] Gayton has commented that among the Yokut of California a shaman's power was derived through dreams but that these dreams were not peculiar to novice shamans; rather, they merely had more of these dreams than the laity. Thus the

difference between the power of a shaman and a non-shaman was one of quantity rather than quality.[158]

Supernatural power was also secured on the vision quest by other Plains tribes, including the Dakota and Pawnee.[159] In contrast to the widespread access to supernatural power found among Plains tribes such as the Plains Cree and Assiniboine, among the Dakota the shaman alone had access to guardian spirits obtained through the vision quest. While the laity had guardian spirits, they were not obtained through the vision quest but rather were assigned at puberty by a shaman.[160] Among the Pawnee the vision quest was accessible to the laity; however, this did not give one the right of entrance to the shaman class. This power was obtained from animal gods "who dwell below," and the shamans were organized into a number of esoteric societies according to their animal guardian spirit.[161]

Once the shaman was elected he entered a training period, a time in which spirit assistants are acquired, which can last several months[162] or many years, such as in the case of Blackfoot shamans who passed through seven "tents" of medicine which typically could take ten to fifteen years or Navajo "singers" who often trained for fifteen years.[163] In most areas of aboriginal North America the shaman could be male or female. A survey of North American tribes by Taylor revealed no bias for sex amongst shamans,[164] In some

areas while both men and women could be shamans, men were regarded as more powerful.[165] According to Mandelbaum, there were many women doctors among the Plains Cree.[166] While girls never deliberately sought visions through the vision quest, they could acquire power during their menstrual seclusion when female spirit helpers could appear.The Northern California area was rather unique in that shamans in this area were usually women.[167]

A hierachy or division of traditional medical practitioners existed in many aboriginal societies. Usually shamans were distinguished by their use of supernatural powers in healing, while medicine men or healers relied primarily upon herbal remedies to treat illness. The shaman was thus at the apex of the hierachy of medical practitioners found in many aboriginal socieities, including the Wisconsin Chippewa,[168] the Navajo,[169] the Micmac,[170] the Assinibione,[171] the Pawnee,[172] the Salish,[173] and the Kwakiutl.[174] Some societies such as the Ojibwa,[175] had a very specialized medical system with a number of specialized practitioners. Often shamans were distinguished by the source of their power, particularly the animal which had bestoyed its power upon them, such as a bear, buffalo or eagle.[176] Mandelbaum reported that among the Plains Cree "shamanism was not confined to the few but was

practised in varying forms and degrees by a good part of the tribe."[177]

The medicine bundle was the most important piece of medical equpiment owned by the Plains Cree shaman and was usually made of the skin of the shaman's totemic animal. The bundle contained fetishes and charms to ward off evil, botanical medicines, and medical devices, such as glass slivers and a sucking horn.[178] Among the Blackfoot, medicine bundles represented power obtained from supernatural beings and could be freely bought and sold. Taboos were observed with the bundles; otherwise illness, such as sore eyes or mouth, boils or blindness, could occur.[179] Plains Cree shamans kept their herbal medicines in small packets, stored in the whole hide of a small animal. These bundles could be purchased or inherited. Mandelbaum has suggested that these medicines were originally transmitted to the Plains Cree by the Plains Ojibwa (Saulteaux).[180] Tlingit shamans would keep a number of split animal tongues, which increased their power, and eagle claws and pebbles wrapped in a sacred medicine bundle.[181]

Also very important to the shaman were eagle feathers, which Park has suggested were univeral among tribes of Western North America.[182] Hultkrantz has commented that the rattle and drum, which were used by the shaman to summon helping spirits and frighten away

evil spirits, were common in aboriginal North America.[183] The use of rattles was common among the Plains Cree;[184] however, Mandelbaum has noted that they rarely used drums for healing purposes.[185]

Masks, representing the spirit which had taken possession of the shaman, were also utilized in some areas, particularly on the Northwest Coast[186] and among the Iroquois.[187] The use of fetishes by shamans to communicate with the supernatural was not common, although they were utilized by Micmac shamans who carved bone into animal fetishes,[188] and among some Plains groups.[189]

Many scholars and researchers, both past and present, have commented upon the efficacy of shamans and healers worldwide. In 1946, Ackerknecht argued that many scholars of "primitive" medicine had overlooked the psychological effects of the traditional healers' treatments.[190] Holland and Tharp have noted that psychotherapy is the oldest curing technique known to man and attempts to "reintegrate the total person into his universe,"[191] and Calestro has pointed out that psychotherapy has ancient roots in religion.[192] Frank has stressed the role therapeutic ritual plays in the alleviation of anxiety for the sick,[193] and McCreery has suggested that therapeutic rituals serve to label and explain illness and allow human beings to respond to illness in "emotionally satisfying ways."[194]

Scholars have discussed "psychotherapy" within aboriginal North American societies, often comparing it favourably to Western psychotherapeutic strategies. In 1932, Pfister noted the ability of Navajo shamans to "hear" the unconscious of the sick, and to instinctively treat them through psychotherapy and psychoanalysis.[195] Leighton and Leighton have also discussed the efficacy of the Navajo shaman, noting that during the treatment the patient's mind is taken off his illness and is focused upon the ceremonial aspects of his/her experiences.[196] According to Sandner, traditional Navajo psychotherapeutic treatments have a true efficacy, based upon ritual and symbolic healing.[197] Devereux has commented upon the compatability of Mohave psychiatric thought and Western psychoanalytic theory, noting that Mohave shamans did not adhere rigidly to one etiological theory of illness; rather, each shaman would have his own etiology of illness based upon his particular area of expertise.[198] Attkinson has argued that the patient's anxiety over his illness is switched to anxiety over the condition of the shaman who may die during soul flight.[199] The shamanic ritual goes beyond mere magical techniques, however. The ritual allows for personal contact with sacred powers which provides the means for healing. Ritual itself frees the patient's mind and allows him/her to temporarily forget the illness and

focus his/her mind on the moment instead of the future. Further, the efficacy of traditional treatments for mental illness through shamanistic techniques parallel Western non-chemotherapy psychological treatments. The elements of consultation and psychotherapy are present in both aboriginal and Western treatments of mental illness.

3.4.2 Diagnostic Strategies

The shaking tent ceremony, also referred to as the spirit lodge or conjuring lodge, was a common diagnostic tool among aboriginal diagnosticians and shamans to ascertain the cause of a patient's illness. Hultkrantz has documented that the spirit lodge complex was generalized to Algonkian groups and was found predominately among tribes of the Northeastern Woodlands, the Plateau and the Plains, and also among Eskimo groups.[200] In 1886, Bell reported witnessing a shaking tent ceremony among the Ojibwa Indians. He noted that poles were driven into the ground in a circle about six feet in diameter and covered with bark to form a tent. The medicine man would then climb inside and begin singing. Soon the tent would begin to shake violently upon the arrival of helping spirits who would provide the shaman with information on the patient's illness.[201]

Common to the shaking tent complex were the themes of the liberation of the shaman from bonds and the magical removal of the shaman from the tent. Soul flight was not common during the shaman's magical removal; however, it was found among the Central Eskimo and several Plateau groups.[202] Also common to the shaking tent complex were reports that shamans were often found suspended at the top of the shaking tent after they had magically freed themselves from their bonds. The spirits of nature (such as thunder, or animals, especially the turtle) acting as helping spirits in the shaking tent prevailed in Eastern areas, while ghosts were frequently called upon on the Plains. Curing rarely took place during the shaking tent ceremony, except among the Arapaho and the Ojibwa. Also, curing could occasionally take place during the ceremony if the patient's illness was due to witchcraft or a trangression of a taboo.[203]

Vecsey has noted that the Ojibwa diagnostic specialist, the djessakind, performed the shaking tent ceremony to determine if the cause of a patient's illness was a witch, ghost or a manitou.[204]. Among the Menominee the diagnostic specialist was known as the "juggler,"[205] and among the Inuit was known as the krilasoktoq.[206]

Among the Plains Cree a select group of shamans utilized a conjuring booth, called a koca.pahtcikan, to

call upon supernatural spirits to aid in diagnosis. The conjuring booth was constructed inside a tipi and was approximately four feet high and four feet in diameter. The booth was constructed out of logs and was covered with robes and hides. The shaman stripped to his breechcloth for the ceremony, which always took place at night. The shaman's hands were bound behind his back, with the similar fingers of the opposing hands tied together. The shaman then knelt down and a thong was repeatedly fastened around his neck and about his ankles, and a rattle was stuck through the thongs on his back. Soon after he entered the booth the shaman's bindings would come flying out of the top of the booth, with each loop still in its original place. The booth then began to shake violently when the spirit powers entered.[207] Hultkrantz has reported that Plains Cree conjurors would call upon the spirits to identify the exact physical location of a patient's illness by directing the conjuror's rattle to the location and hitting the spot.[208]

Several other diagnostic techniques were found in aboriginal North America, including obtaining the information from a "dreamer" (non-shaman who dreamt of the patient's illness) among the Kwakiutl,[209] or gazing through a quartz crystal among the Acoma of New Mexico.[210]

3.4.3 Spirit Intrusion and Spirit-Caused Illness

Illness within aboriginal North America could be caused by the intrusion of spirits into the victim's body. As well as illness resulting from spirit intrusion, namely a spirit entering the body, illness could be caused by a spirit which remained external to the human being's body. This can be termed spirit-caused illness, as opposed to spirit intrusion.

In his seminal monograph, Primitive Concepts of Disease, Clements reported that spirit intrusion was found among the Dakota, Eastern Cree and Northern Sauteaux; however spirit intrusion was not reported among the Dene Indians.[211]. Murdock has suggested that the attribution of illness to spirit intrusion is universally one of the most wide-spread and common theories of disease causation.[212] The intruding agent was usually a supernatural entity, such as a soul, ghost, or evil spirit. According to Fejos, the patient's body could begin to waste away when the supernatural entity entered it because the entity fed on the food the victim consumed.[213]

One of the most frequently commented upon disorders of North American Indians, and in particular the Northern Algonkian peoples, is Windigo, which provides a good example of spirit intrusion. According to the Windigo mythology, the Windigo figure is a giant cannabalistic skeleton or monster made of ice who lives

in the winter, enters the body of human beings and transforms them into Windigos. The mythology also suggests that these individuals then come to crave human flesh and that there was typically no treatment for a human-turned-Windigo; rather, he/she had to be killed.[214] The Windigo belief complex seems to represent a mythology generalized to many Indian tribes which grew out of environmental conditions. The threat of starvation is evident in the Windigo or Windigo-related myths, which all include a winter cannibalism theme, and thus appears to have been an environmentally-caused condition with culturally-defined symptoms.[215] In an examination of trials involving accused murderers of Windigos, Schuh reported cases occuring on the Berens River reserve in Manitoba in 1897, in Sturgeon Lake, Alberta in 1899, at Smoky River, Alberta in 1900, and at Great Slave Lake, N.W.T. in 1899 and again in 1921.[216] In the course of field work among the Athapaskan Beaver Indians of the Peace River area, Ridington found the belief in a parallel Windigo figure, Wechuge, to still be in existence.[217]

Spirits which remained external to their victims could also be a serious cause of illness. A classic example of this is ghost sickness which occurred when ghosts deformed living persons by twisting their face, hands and arms. Devereux has reported that the symptoms

of ghost sickness among the Mohave included a fear of the dark, insomnia, nightmare and excessive crying.[218] Ghost sickness has also been reported among the Apache,[219] and the Comanche.[220] In the Swimmer Manuscript, Mooney and Olbrechts provide an extensive discussion of the Cherokee disease belief system. A major cause of illness among the Cherokee was ghosts, which could be in human or animal form.[221] Luckert has commented upon the contemporary belief in coyote illness among the Navajo, which is quite similar to ghost sickness in terms of its physical symptoms.[222] According to Mandelbaum, the Plains Cree believed that the soul, ahtca.k, which resided along the nape of the neck, entered the body at birth and left upon its death. Upon death one's soul entered the land of the dead, but some souls returned to earth to haunt men, such as when a suitable funeral feast was not given. These souls were called tcipayak, or ghosts, and were recognized by strange noises. Mandelbaum does not note any specific illnesses caused by these ghosts; rather, their main mission was to frighten specific living persons to compel them to provide the necessary feast or ceremony.[223]

The Coast Salish have traditionally been subject to spirit illness (sy∂'∂w n), a disease etiology which is still prevalent today. This condition is characterized by anorexia, insomnia and general

weakness. Whereas many forms of spirit intrusion are the result of malevolent spirits, spirit illness among the Coast Salish is associated with one's guardian spirit. Jilek has suggested that spirit illness is very similar to the illness associated with the ecstatic initiation of shamans. In the winter those individuals who have acquired dancing power become ill, ranging from feelings of loneliness to severe illness with localized pain. Newly initiated dancers often have difficulty controlling their guardian power and can easily develop power illness, which is pacified only through participation in the Spirit Dance.[224] Haeberlin has also noted that the Coast Salish traditionally believed that the loss of one's guardian spirit could cause psychic illness.[225] An individual's guardian spirit was carried to the land of the dead, and if it was not retrieved by shamans the person could die.

Spirit illness among the Coast Salish presently is cured through the Spirit Dance. The Spirit Dance was traditionally a major ritual of the Salish-speaking peoples of the Northwest Coast and was associated with the guardian spirit complex. Jilek has reported that the rhythmic drumming of deer-hide skins is of paramount importance to this ceremonial.[226] The Spirit Dance was renewed in 1967 among the Coast Salish and is playing a major role in combating alcohol and drug abuse among this population. The dance, held in the

winter months, is the means by which an individual acquires his Indian power. Through the name-giving ceremony an individual receives his ancestral name and gains his Indian identity. Jilek has stressed that there is a pressing need for such traditional therapies in the Upper Fraser Valley because of high winter unemployment and the concomitant degree of alcoholism and drug abuse. Jilek has ranked the Spirit Dance as being at least as successful for Indian people as other major forms of therapies for alcohol and drug abuse.[227]

Park has suggested that the principle prevailing through shamanic curing for spirit intrusion is that treatment will only be successful if the shaman has among his spirit-helpers one who has power over the intruding spirit.[228] Johnson has reported that exorcism techniques to expel evil spirits from a victim's body were generalized among Northern Algonkian tribes.[229] One of the most common means for forcing evil spirits out of the body, not only amongst these groups but universally, was the sweat bath.[230] Macdonald has reported on the use of the sweat lodge by Indian groups in New Brunswick for this purpose,[231] and Vecsey has noted that the Ojibwa similarly utilized the sweat bath to expel maleovolent supernatural powers from the body.[232]

3.4.4 Soul Loss

Soul loss illness usually occurs when the soul has left the body either on its own through a dream or through theft by malevolent spirits or human agents.[233] Murdock has noted that the attribution of illness to soul loss is found in cultures which see human beings as having souls which normally reside in the body but are capable of leaving temporarily during dreams and leaving permanently upon death.[234] An individual suffering from soul loss becomes ill and can die if the soul is not retrieved.[235] The symptoms of soul loss, according to Rubel, are loss of appetite and strength, difficulty sleeping, introversion and depression. Other symptoms include localized or generalized pains and fever.[236]

Clements notes that the concept of soul loss was generally absent on the Plains, but was found among the Dakota Indians, as well as the Eastern Cree, Northern Saulteaux, Ojibwa and the Dene.[237] Traditionally, one of the most frequent causes of soul loss was dreaming.[238] Shamans were especially subject to losing their soul during sleep as their powers can be angered when awakened.[239] The Ojibwa saw soul loss as a major causative factor in disease, according to Vecsey, and believed that the soul could wander in a dream.[240] Hahn has noted that a person who was insane was said by the Ojibwa to be kawin otcatca'kwst (no soul).[241]

Interestingly, Clements has reported that the Ojibwa believed that the gall bladder was the seat of the soul.[242] Hallowell has reported that among Saulteaux groups it was believed that a shaman could abduct the soul of a sleeping victim. The shaman took the soul into his conjuring tent and attempted to kill it. If the soul managed to escape and return to its body the individual would suffer illness but not death.[243]

A second major cause of soul loss was the stealing of one's soul by a malevolent spirit or human agent. Clements has noted that among a number of groups of the Great Basin, American Southwest, and Northwest Pacific Coast the soul was closely associated with the heart and was often known by the same name. It was believed that sorcerers or evil spirits could steal the "heart" (soul) of an individual.[244] Elmendorf has similarly recorded that a number of Pueblo groups of the Southwest believed that their "heart" could be stolen.[245] Vogel has noted that some of the Huron Indians believed that their souls were stolen by the Jesuit priests.[246] The Netsilik Inuit believed that shamans could have their souls temporarily stolen by their tunraqs (protective spirits).[247] According to Corlett, Western Inuit groups believed that the shadow of a dead man could steal the soul of a living person.[248] The Chinook of the Northwest Pacific Coast believed that the stolen soul was eaten by its

captor.[249] Kunitz has discussed the belief in soul-related disease in contemporary Navajo society. The ghosts of the very old and very young are not considered potent causes because their souls are not well attached; however, the ghosts of those who die while their souls are well-attached (the middle-aged) can cause serious illness.[250]

The most common port of exit for the soul appears to be the head. This concept was found in the Great Basin, Plateau, and Northwest Pacific Coast areas and was present among the Dene. When the shaman retrieved the lost or stolen soul he returned it to the body through the patient's head.[251] Hultkrantz has noted that it was the responsibility of the shaman to retrieve lost or stolen souls in many cultures.[252] If the soul had been carried away by the dead, the shaman sent either his own soul or his guardian spirits to the land of the dead. The shaman was in constant danger of being caught while in this land and would often battle for his life with the spirits of the dead. Johnson has noted that shamanic soul flight in many cultures was induced through hallucinogenic drugs such as peyote.[253] Menominee shamans would suck the patient's soul into a reed whistle, plug it with cattail down and place the whistle on the patient's chest. In four days the patient's soul returned to its body.[254] The Haida shaman would fast for several days and then walk

through the forest, looking for his patient's soul. When he saw the lost soul he caught it between the palms of his hands and then returned it to the patient.[255]

3.4.5 Disease-Object Intrusion and Witchcraft

Disease-object intrusion is the belief that foreign objects have been projected into a victim's body by a malicious human agent resulting in illness, such as listlessness, fever, spasms, or swelling of a region of the body.[256] According to Clements, this disease etiology was found among the Dakota, Eastern Cree, Northern Saulteaux and the Dene.[257]

The Ojibwa believed that feathers, shells, stones, worms and insects could be projected into the body,[258] and Western Inuit groups believed that pieces of bone or wood could be projected into a victim.[259] Other objects commonly projected were snakes, arrows, thorns, and small animals.[260] The Crow Indians of the Plains believed that insanity could be induced by inserting a tooth or lock of hair from a dead body into a living person.[261] In a very unique North American aboriginal example of disease-object intrusion, the Omaha and Ponca Indians of the Plains believed that dental disease was due to the intrusion of worms into the body.[262] Hultkrantz has noted that the diagnosis of disease-object intrusion is based upon bodily pains,

and has argued, contrary to many scholars, that the etiology of disease-object intrusion is no older than the etiology of soul loss.[263]

The human agent involved in disease-object intrusion traditionally was either a witch, shaman, or sorcerer. Murdock distinguished between witchcraft and sorcery, with witchcraft defined as being restricted to a special class of instrinsically evil human beings believed to be endowed with special powers. In contrast, sorcery can be practiced by anyone. According to Murdock, sorcery theories of illness were traditionally common in societies such as those of aboriginal Western North America where access to supernatural power was widely distributed among the population through the vision quest.[264]

Witches and shamans were closely identified with bears in some regions. Among the Navajo, witches were thought to be active at night, roaming about in bear skins.[265] Bear doctors, who would commit up to four murders per year, were found among the Pomo and other tribes of California.[266] They would take unsuspecting victims to their cave where the victims were slain.[267] Bear medicine men were also found among the Sioux of South Dakota, although they did not necessarily practice with evil intent.[268] The Ojibwa particularly feared bearwalkers, witches who disguised themselves as bears either by wearing bear skins or by

metamorphasizing into a bear, and travelled at night causing disease in their victims.[269]

Owls were closely associated with witches in the American Southeast and on the North Pacific Coast. Mooney and Olbrechts have noted that the word for "witch" in the Cherokee language is the same as the word for "hooting owl."[270] In a survey of monographs of shamanism of the North Pacific Coast, Barbeau has recorded that witches were known by the same name as the screech-owl (st!ao).[271] According to Howard, the Oklahoma Seminoles attributed a great deal of illness to witchcraft and believed that witches took the form of a horned owl when engaged in evil activities.[272]

In the Plains and in the Great Basin regions evil shamans were usually motivated by jealousy. The Comanche puhakut, or healer, would "witch" an individual they envied, inflicting witch sickness through the use of ghost medicine. The symptoms of this condition were spasmodic contortions of the face, hands and arms, an inability to keep food down, fever, and general listlessness. An evil puhakut would cause an eagle feather to enter the body of his victim; this was known as "shooting the feather." The feather would enter below the skin of the victim and move rapidly throughout the body until it lodged, causing death unless another puhakut could successfully remove it.[272]

Among the Plains Cree, objects were often sent by jealous shamans who envied a person's accomplishments. To send an object a shaman held it on the palm of his hand, addressed his spirit helpers, and blew the object pitcitcihtcikan or "something moving" toward his victim. The evil object was then carried away and entered the body of the victim.[273] The Plains Cree particularly regarded the Saulteaux and the Wood Cree medicine man as practitioners of "bad medicine" who fought through magical means, projecting objects into their victims. Additionally, Saulteaux shamans were known for their "love potions" or "love medicines" which could cause an individual to fall inexplicably in love with the individual sending the medicine. Hence, the Plains Cree were very careful not to offend visitors from these tribes. Indeed, Mandelbaum has suggested that the concept of "bad medicine" was transmitted to the Plains Cree by the Saulteaux.[274]

"Bad" medicine men among the Plains Cree would also utilize effigies in order to project an object or evil medicine into a victim. The effigy could be made out of clay in which case an intrusive object was inserted into the body of the figure, or could be fashioned out of hide in which case evil medicine was placed over the area of the victim to be affected.[275] Sorcerers among the Navajo also would create an effigy of an intended victim, which was pierced with a sharp

object.[276] Shaman, or buowin, among the Micmac would create a bone effigy of another shaman, which they would pierce with a sharpened stick or a needle. They would then concentrate their power and their victim would become injured in the area analagous to that pierced on the effigy.[277] Witches could also magically poison their victims,[278] which Kennedy reported in 1984 to be the major disease etiology in Okanogan-Colville society.[279]

A sucking or cupping technique was commonly utilized in cases of disease-object intrusion. Clements has reported that the sucking technique was traditionally generalized on the Plains although it was not found among the Dakota Indians. This technique was also found among the Dene, but not among the Eastern Cree or Northern Saulteaux.[280] Through clairvoyance the healer would determine the location of the disease and remove the object through the application of a sucking horn.[281] The sucking horn was usually a hollow bone or animal horn.[282] Darby reported in 1932 that the sucking technique was common among tribes of British Columbia.[283]

Several cultural groups had sucking doctor specialists. Among the Ojibwa, the sucking doctor's treatments included sweat baths, herbal cures and prayers. Often a medicine stick (a nine inch long stick which was filled with clay and had a hoop at one end

and a leather thong at the other end) was utilized to pry loose the disease-causing object by hitting the patient's body and sucking out the object.[284]

The Plains Cree did not have a cupping or sucking specialist; rather the shaman was responsible for employing the sucking treatment. The shaman would blow over the patient's body and then place his mouth over the affected part and suck out the cause of the illness. Sometimes the shaman would utilize a horn or a piece of gun barrel to suck out the cause of the illness. The illness was usually the result of an intrusive object, such as an insect, piece of flint, or a twig. Also, illness could be the result of a foul-smelling substance which the shaman spat out upon sucking the illness from the patient's body. The shaman who was attempting to suck out the illness out had to be stronger than the shaman who had sent the illness. Once the intrusive object was removed the malicious shaman would die.[285]

Another method of treatment for illness due to disease-object intrusion was blood letting. This was done by making small incisions in the skin at the point where the intrusive object lay. Ritzenhaler has noted that the Wisconsin Chippewa cupping specialists utilized blood letting in conjuction with the sucking treatment.[286] Treatment of witch sickness among the Comanche also involved blood-letting in conjuction with

sucking until the disease-causing object had been removed.[287] The blood-letting treatment was also common among the Choctaw and Creek Indians of the American Southwest.[288] In 1883, Andros reported that blood-letting was so common among the Dakota Indians that, "You will scarcely see an Indian of any age who has not the scars of scarification about the temples or neck."[289] The Arapaho of the Plains also utilized blood letting,[290] and Mandelbaum reported that the Plains Cree frequently utilized this technique.[291]

Several other techniques were utilized by healers to treat patients suffering from disease-object intrusion. Kluckhohn has reported that among the Navajo, the victim of witchcraft could be cured if the witch confessed to his actions. Gradually the victim would improve and the witch would be afflicted with the same illness which had been inflicted upon the victim and would die within the year.[292]

According to Howard, illness due to disease-object intrusion among the Oklahoma Seminole was also treated by killing the witch. In this case the witch was killed by a witch hunter who utilized a special arrow (stikini arrow) with owl feathers and small grooves cut near its point, which were filled with herbal medicines. The witch hunter would remove all of his clothing, except his shoes, circle the witch's house once in a counter clockwise direction and shoot the stikini arrow.[293]

Barbeau has reported that to treat victims of "wizardry", Northwest Coast shamans would expell the white mice residing inside the wizard (often said to be as many as ten mice). Once the last mouse, which was always white, had come out the patient would recover. If the shaman did not know where the wizard was he would take a live mouse and repeat the names of all the town's members before the mouse. When the shaman named the wizard the mouse would give him a sign by moving its head.[294]

3.4.6 Taboo Violation

Another very imporant disease etiology in aboriginal North America was taboo violation.[295] A major symptom of taboo violation was a generalized feeling of malaise.[296] Taboo violation has been reported as a cause of illness among the Dene,[297] Dakaota, Saulteaux [298] and Plains Cree.[299]

Shamans or the laity could become ill because of a violation of a personal taboo.[300] Individuals could also become ill because of the sin of a parent or ancestor. This "sins of the fathers" concept of disease was not widespread and was found primarily on the Plains, among the Arapaho, Saulteaux and Dakota tribes. The concept was also found in the Great Basin region among the Comanche. According to Wallis and Wallis, among the Dakota Indians the sinner was not affected by

his transgression but one of his descendants could be striken with illness or be born with a bodily defect.[302] This concept was also found among the Ojibwa in a limited sense. It was believed that an individual who sought too much power could endanger his descendants.[303] Violation of taboos connected with ceremonials could also cause illness.[304]

As well as personal taboos having to be observed in order to maintain one's health, a wide range of food taboos had to be observed, such as abstinance from certain foods.[305] Among the Plains Cree, a man's spirit helper could impose a food taboo and failure to provide proper offerings to these spirit powers could result in harm coming to the individual.[306] Also, a strong taboo existed among the Plains Cree in regard to the seclusion of young girls for their first menstruation for it was believed that if they were to look upon men the latter could lose their guardian spirits.[307]

Confession played a major role in treating illness resulting from taboo violation in many societies.[308] La Barre has noted the virtual pan-American presence of the confession ritual in aboriginal societies, and argued that the ritual did not develop from the influence of Jesuit missionaries as some scholars have suggested.[309] The confession ritual played a major role among Dene,[310] Dakota,[311] Saulteaux,[312] and Plains Cree[313] groups.

Hallowell has concluded that confession as a treatment for taboo violation was institutionalized among the Saulteaux.[314] Secret sins would also be confessed by the Saulteaux in order to cure the illness afflicting an offspring. La Barre has also emphasized the Saulteaux's belief that sickness was the result of sins, particularly sexual ones, which could be cured only through confession.[315] Public recounting of illicit sexual relations was also very important among the Plains Cree. A tent would be erected over a buffalo skull or spirit stone and the men would gather to confess sexual sins in order that misfortune would not befall them.[316] The confession ritual was generalized on the Plains. Apache shamans would elict public confessions from patients who failed to volunteer the information. Similarly, the Blackfoot, Iowa and Crow Indians utilized the public confession ritual.[317] Illness resulting from the sins of the ancestors were treated by Dakota shamans by diagnosing the sins in a vision and then stating the sin out loud.[318]

3.4.7 The Peyote Ritual

An aboriginal ceremony which is still widely utilized today, especially in the treatment of alcoholism, is the peyote ritual. The peyote button contains nine narcotic alkaloids.[319] La Barre has noted that in pre-Columbian times the Aztecs and other

Mexican tribes would eat dried peyote buttons and dance around a ritual fire all night in the context of agricultural and hunting religious ceremonials.[320] According to Troike, peyotism gradually came to replace the mescal bean medicine society complex which had spread into the Plains region.[321] The peyote ritual spread into the Great Basin region after 1870.[322] Vecsey has suggested that while some Ojibwa participated in the peyote religion, it was opposed by the mides (priests) of the Midewiwin and never gained widespread success.[323] In 1983, Kunitz argued that the peyote ceremony, which lasts only one night and has a single, standardized ritual which is relatively easy to learn, was taking the place of the traditional Navajo healing ceremonials, which could last nine nights.[324]

Peyote has many medicinal puposes and among a number of Indian tribes, such as the Navajo, Delaware and Comanche, the same word is used for "peyote" and "medicine."[325] Anderson has compared the use of peyote to the use of aspirin in Western culture. In other words, peyote is used as a general medicine to relieve pain and facilitate healing.[326] Anderson has noted that whereas Mexican Indians primarily used peyote to act as a barrier to protect against witchcraft, American Indian tribes used peyote after they were ill in the belief that peyote could purge the body of evil spirits.[327] Aberle has suggested that peyote meetings

were traditionally held for virtually all physical and mental illness, with the road chief of the ceremony taking the disease of the patient upon himself.[328] In an extensive discussion of a Comanche medicine woman, Jones noted that peyote was her most utilized general medicine. The medicine woman believed that peyote was the most powerful of all plant medicines and could heal any human affliction.[329] Peyote was also an important medicine in the therapeutic kits of Potawatomi shamans.[330] La Barre has commented upon the wide range of diseases that peyote could traditionally cure, including goiter, pneumonia, syphilis, tuberculosis, cancer, skin diseases, malnutrition and insanity.[331] Vomiting of peyote is considered to be punishment for one's sins and rids the body of its impurities. Peyote can be used in both "white" and "black" medicine, with witches utilizing it to make another individual ill. La Barre has noted that a "father" peyote button was handled with great reverance and certain buttons were passed down through the generations. The father peyote button acted as a fetish which sat upon an alter during the peyote ritual. Healers would often have a number of father peyote buttons, with each button having its own history in terms of the patients it had cured.[332]

The role of peyote in alcoholism treatment among the Indian population has been discussed by Albaugh and Anderson. They have noted that the use of peyote in the

Native American Church may provide a cathartic release for expression of one's feelings of alienation and isolation.[333] Clearly, the peyote ritual is one example of an alcohol treatment matching the philosophy of the patients. This ritual has been found to be more successful for Native alcoholics than Western modes of alcoholism treatment.[334] The use of the peyote ritual in the treatment of alcoholism appears to be quite widespread, with Roy et al. arguing that the majority of Indian non-drinkers in Saskatchewan are previous alcoholics who gave up drinking through participation in the peyote cult.[335] Researchers such as Bittker [336] and Shore and Fumetti[337] have criticized the alcohol treatment programs available for Natives; perhaps peyote has a real role to play in the treatment of Native alcoholics.

Wallace has contrasted the responses to mescaline intoxication (which is very similar to peyote intoxication) between Indian and non-Indian subjects. While non-Indian subjects felt a loss of contact with reality and a breakdown of social inhibitions, Indian subjects felt contact with a higher-order reality and maintained "proper" behavior. Wallace concluded that while the non-Indian gains no therapeutic benefit from mescaline use, the Indian gains "marked" therapeutic benefits, especially in terms of a reduction in chronic anxiety.[338] Bergman has also reported a very low rate

of negative reactions to the peyote experience among the Navajo. He suggested that this was because the peyote meetings are carefully channelled into an "ego-strenthening" direction with an emphasis upon the real, interpersonal world. Further, the "roadmen" in the meetings are trained to watch people who are becoming excessively withdrawn after ingesting peyote. If a person is withdrawing the roadman goes to this individual and speaks with him in order to draw him back into reality.[339]

Pascarosa and Futterman have compared the roadman to the Western psychotherapist, for the roadman utilizes psychotherapeutic techniques and facilitates group interaction and confession. Further, the roadman has a profound knowledge of Indian culture and thus can assume a leadership role. According to Pascarosa and Futterman, the peyote ritual provides more than just a cure for alcoholism as it allows self-actualization and spiritual consciousness for Natives which they argue are absent from most Western alcoholic treatment centres.[340] Similarly, Aberle has suggested that the prayers of the peyotists alleviate the anxiety of feelings of helplessness.[341]

3.4.8 The Sweat Lodge

The near universal use of the sweat lodge, or the steam bath, among North American aboriginal societies

has been documented.[342] The sweat lodge represents the vehicle by which Native peoples can communicate with greater powers, and the heat and sweating endured is believed to be a form of suffering for these powers.[343] Vogel has concluded that the sweat bath was a panacea for virtually all diseases, with immersion in a stream or lake often following the ritual, and has suggested that the sweat bath was traditionally also common to many other cultures.[344] Mandelbaum has provided a good description of the typical Plains Cree sweat lodge. The dome-shaped structure was four feet high and six to eight feet in diameter; willow withes secured in six holes dug in a circle were arched over and intertwined to form the frame. Robes, blankets or tipi covers were laid over the frame and a circular hole within the structure was filled with heated stones. The sweat lodge could only be used once; however, the frame was left permanently intact.[345] The dome-shaped sweat lodge appears to have been generalized among Eastern tribes as well.[346] Among other groups, clay was used to cover the frame, and live coals were also utilized in the lodge as well as stones.[347]

Among the Plains Cree, the sweat bath was part of virtually all ceremonial activity. Sweats were undertaken for ritualistic cleansing before participation in a ceremony, as an offering to a spirit power, or simply for pleasure. In a typical ceremony,

sweetgrass was burned and a pipe was offered around to all. The lodge was then closed and water was sprinkled on the hot stones. Four songs were then sung and the cover of the lodge was lifted slightly to let in some air. Two or three more songs were sung and the bathers left the lodge and laid down on the ground to cool off.[348] Sweats were also central to Dakota healing. [349]

Botanical medicines were sometimes placed on live coals or rocks in the sweat lodge. The Ojibwa would place white cedar needles on coals,[350] and a number of Plains groups used red cedar twigs.[351] Tribes of the Missouri Valley used wild mint in the sweat bath and also would use purple coneflower to make the heat of the bath more bearable.[352] The Potawatomi would place witch hazel in the sweat lodge as a treatment for sore muscles, while the Menominee utilized hemlock leaves for this same purpose.[353] Taylor has noted that on the Northern Plains sweat lodges were often constructed from a frame of willow or conifer branches. Willow bark contains salicin, the active ingredient in aspirin, and acts as an analgesic, while the oil from conifer is a decongestant.[354]

3.4.9. Sweetgrass

Sweetgrass was traditionally widely utilized in Plains Cree society, being common to most ceremonials. The grass was gathered when it was long and then was

braided. Prior to beginning a ritual, and at frequent intervals during the ritual, a piece of the braid was broken off and set on live coals. The smoke was seen as a purifying agent, and its aroma was believed to please supernatural spirits. Pipes, drums and virtually all ceremonial paraphenalia was passed through a sweetgrass smudge. Those handling sacred bundles would wash their hands in the smoke and draw it into their bodies before touching the bundle.[355] Sweetgrass smudges played an important role in the ritual preparations for the sun dance, with three smudges burning outside the tipi and one smudge burning in the middle of the singer's circle. Sweetgrass was also used in the ritual sweat bath which accompanied the first thunder of the spring.[356]

Sweetgrass was traditionally believed to ensure good "fortune" and good health. A sweetgrass braid was dipped in water and the water was splashed on hot stones inside the sweat lodge.[357] Sweetgrass is still commonly burned in Plains Cree and Saulteaux sweat baths.[358] While traditionally common to the Plains region, Mandelbaum reported that the use of sweetgrass was absent among Eastern tribes.[359]

3.5 Traditional Health Care Systems Today

3.5.1 Utilization of Traditional Health Care Systems

It has been argued by Ragan that globally "the importance of the traditional practitioner cannot be underestimated."[360] Ragan estimates that the number of people using traditional medical systems worldwide exceeds that of Western medicine by a factor of 2 to 1.[361] Research on the utilization of traditional health care systems in non-Western and Western countries where the Western health care system is also in place demonstrates that indigenous populations still seek out traditional healers and medicines.[362] Kleinman has reported that in the major urban centres of Taiwan, such as Taipei, where the Western health care system is also prominent, the traditional healer (tang-ki) is still sought out by many patients.[363] As early as 1959 Press noted the "dual use" of both traditional and Western medical practitioners in the urban centre of Bogota, Columbia.[364] Similarly, in a recent article Ladinsky reported that Vietnamese frequently utilize both traditional and Western health care systems, with traditional systems being used more for minor illnesses and the Western system being used for more serious diseases.[365]

Immigrant populations within North American urban centres have also been found to utilize traditional healers. Rappaport and Rappaport have found that traditional healers are active among Black, Mexican-American and Hispanic populations in the United States.[366] Ruiz and Langrod have reported on a study at a community mental health centre in New York which concluded that at least half of the Puerto Rican patients were also visiting spiritists (traditional Puerto Rican healers).[367] New and Watson discovered that Chinese patients in St.Catherines, Ontario utilized traditional healers rather than Western physicians because Chinese healers could communicate with them in their particular expression of symptoms, such as an imbalance of Yin-Yang.[368]

As stated previously, research on the utilization of traditional healers by urban North American Native populations is very limited. In 1974, Fuchs discovered that significant numbers of Native Americans living in San Fransisco utilized traditional healers.[369] In 1975, Fuchs and Bashshur concluded that traditional Indian medicine was still being utilized by significant numbers of Natives living in the San Fransisco Bay area.[370] The only Canadian research to include an investigation of the utilization of traditional medicine by an urban Native population was a study by Mears et al. of the skid row Native population of

Vancouver. The researchers found that few people utilized traditional healers and medicines; however, this could reflect the fact that this population is transient and may lack knowledge of health care alternatives, such as traditional health care systems.[371]

Non-urban Canadian Native populations are also utilizing traditional healers. In a recent article, Gregory and Stewart have reported that many Native people in Northern Manitoba are now requesting traditional healers in their health care.[372] Similarly, Speck has suggested that Western medical treatment is occasionally delayed by Natives in British Columbia until a traditional healer is consulted.[373] Kennedy has reported on the manner in which Native patients may alternate between traditional and Western health care systems for treatment of the same illness episode.[374] Similarly, Mardiros has commented on the use of both health care systems by Canadian Natives.[375] Gregory has suggested that many Native people find it necessary to utilize both the Western and traditional health care systems for many illness episodes.[376] Thus while the information and research is sparse in the area of utilization of traditional health care systems by both urban and non-urban Canadian Native populations it seems that there is a real, perhaps renewed, desire for access to this system by Native populations.

3.5.2 The Integration of Traditional Healers into the Western Health Care System

Traditional Native healers have not been integrated into the Western health care system to any extent; thus, there is a lack of information in this area. A few isolated programs and facilities have integrated traditional healers into the Western health care system in the United States and Canada. Kahn and Delk have noted that the mental health clinic on the Papago reservation utilizes Papago medicine men to treat psychiatric patients.[377] Similarly, Haven and Imotichey have discussed the integration of two traditional healers into the Department of Community Mental Health and Alcoholism of the Miccosukee tribe of Florida, and the use of Indian medicine in the mental health program of the Special Services Department of the Seminole tribe of Florida.[378]. Guilmet has commented on the use of traditional healers within the tribal-run medical clinic of the Puyallup Indians of Washington State where a permanent sweat lodge is maintained at the alcohol-drug treatment facility of the clinic.[379] Bergman has outlined a school for medicine men near the Navajo reservation, funded through the National Institute of Mental Health. This program began in 1969 and teaches students traditional Navajo ceremonial chants.[381] In general, however, traditional healers have not been widely available

within the Western health care system in the United States. In a review of forty-five American reservations, Attneave found that few reservations had developed any sytematic collaboration between traditional healers and health programs.[381]

Traditional healers have also not been made widely available to Natives within the Western health care system in Canada, especially in the urban context. Gregory has noted that an elder is employed at the Poundmaker lodge, a Native alcohol treatment centre, in Edmonton.[382] It should be noted at this point that elders are regarded as guardians of Native culture who are endowed with the right of passing on the history, genealogies, legends, and myths of their peoples through oral tradition. Elders usually do not practice traditional medicine; rather, this role is mainly confined to traditional healers. Peterson has commented on a Native healers program in Kenora, Ontario which was set up to deal with the rampant alcoholism among the Native population in that area. Initially the healers worked in the local hospital, but it was found that this conflicted with the traditional ways of healings, and the healers began to work through a local Native organization.[383] Shah and Farkas (1985b) have noted that "culturally-sensitive" substance-abuse programs have been developed in Calgary, Edmonton, Lethbridge, Toronto and Winnipeg although they do not

state whether traditional healers or medicines play a role in these programs.[384]

Traditional healers and elders have been integrated into the Western health care system to a greater extent on Canadian reserves. Gregory has reported that elders have been employed by the Shamattawa band in Northern Manitoba to counsel young people with solvent abuse problems.[385] According to Mardiros, traditional healers are now beginning to play an important role as members of the health care teams of reserves, along with health care professionals and auxiliaries.[386]

The degree of collaboration between health care professionals and traditional healers is not very extensive, however. In an examination of collaboration between nurses, elders and traditional healers on Manitoba reserves, Gregory discovered that collaboration between these groups was very limited and the majority of nurses interviewed felt that Medical Services provided them with an inadequate orientation to Indian culture.[387] Psychiatrists Wolfgang Jilek and Louise Jilek-Aall are somewhat unique in that they collaborate with traditional Salish healers in their practice in British Columbia. They have noted that in contrast to Western therapists, the traditional healer works "with and through the patient's extended kinship and tribal network," and have stressed the need for

alternative psychotherapies for some Native patients.[388]

Although there is a lack of integration of traditional healers into the Western health care system, there have been calls for a recognition of the importance of traditional healers in Native health and mental health care. Borunda and Shore have argued that the most severe emotional impairments are found among those urban American Indians who have the least access to traditional health care systems.[389] Similarly, a 1978 Task Force on the Mental Health of Canadian Natives suggested that in some cases traditional Native treatment modalities would be much more effective in the treatment of mental illness among Native patients than Western modes of treatment.[390] A 1979 Canadian National Commission recommended a nation-wide program under Native jurisdiction which would train Native people in traditional medicine.[391] Segal, in a Medical Services publication, also stressed the necessity of training a new generation of traditional healers.[392] Gregory has noted that a 1980 Indian health discussion paper advocated a "closer working relationship" between traditional healers and physicians; however, argued Gregory, this recommendation has not been acted upon. Gregory stated:

> It would appear that the government acknowledges the relevance and utility of traditional healing approaches within international and national political organizations but has not actively nor

> formally initiated collaborative or interactive efforts between staff at the field level...and members of the traditional health care system.[393]

Recently, in a presentation to the Saskatchewan Commissions on Directions in Health Care a representative for the Native Council of Canada spoke for the need of healers to be part of the health care system in Native communities.[394]

Thus while it appears there is a desire for access to traditional healers and medicines amongst the Native population of Canada there really has been very little attempt made on the part of either the government or the medicial establishment to provide this access. This especially seems to be true in urban centres where little or no commitment to providing access to traditional health care systems, or for that matter any type of "culturally-sensitive" health care, exists. Difficulties also arise because traditional healers themselves often are reluctant to participate in the Western health care system and prefer to keep traditional health care systems confined to reserves.

CHAPTER FOUR: RESEARCH METHODOLOGY

4.1 Research Setting

The Parklands region of Saskatchewan, as identified by the Federation of Saskatchewan Indian Nations (F.S.I.N), consists of a broad strip across central Saskatchewan, including the city of Saskatoon which presently has a population of 180,000. Within this region there are thirty-three Indian bands, the majority of which are Plains Cree. According to an estimate by F.S.I.N., three-quarters of the Treaty Indians in Saskatchewan are Cree and are concentrated largely in the Parklands.[395] The other major tribal groups in Saskatchewan, as identified by F.S.I.N., are Chipewyan, Saulteaux and Sioux. The Cree tribal grouping is further divided into Plains, Woodlands and Swampy Cree.[396]

Estimates of the Native populations in urban centres such as Saskatoon are not precise and often wide descrepancies exist between estimates. In 1983 Clatworthy and Hull projected the Saskaton Native population to be approximately 11,000 in 1986 (it was estimated at 7,600 in 1982).[397] Other estimates put the Saskatoon Native population as high as 23,000 in 1986.[398] The 1981 census, according to Farkas and Shah, put the Saskatoon Native population at 4,235,

although this figure may represent the status Indian population only.[399] The influx of Natives to Saskatoon began in the late 1960s and continued through the mid 1970s. A 1983 F.S.I.N. report suggested that this off-reserve migration began to slow down in 1976, with only 3% increases in the Saskatchewan urban population between 1976-1981 and 1981-1986, as compared to an 11% increase from 1966-1971.[400] Clatworthy and Hull reported that the Saskatoon and North Battleford districts (as defined by Indian and Northern Affairs Canada) represent the most common rural origin for the Saskatoon status Indian population.[401]

It must be kept in mind that urban Natives often live a "bi-cultural" experience, participating in two somewhat different cultural milieus, because of movement between the city and the reserve. Urban Natives may not live exclusively in the urban cultural environment with its strong Western orientation, but may alternate between the urban and reserve environments. Indian cultures are also present in the city, especially in a ghettoized area where there exists a high concentration of Natives as is the case in the neighborhoods surrounding the Westside clinic. One common yet important element of urban Indian cultures is the bilingualism (a Native language and English) of the people (over three-quarters of the respondents in this study could speak at least one

Native language). Thus urban Natives are able to maintain and experience Indian cultures within the city, although these may be somewhat different from that of the reserve.

The age structure of the Saskatchewan status Indian population is significantly different from that of the non-Indian population, having a much higher percentage of young people (0-14 years) and a much lower percentage of elderly people (65+ years). Accordingly, the majority of the urban status Indian population of Saskatchewan is concentrated in the younger age groups, with Indian and Northern Affairs Canada estimating that 43.1% of this population is concentrated in the age group of 0-14 years.[402] Similarly, Clatworthy and Hull estimated that 70-75% of Indian migrants to Saskatoon and Regina from 1978-1982 were children and young adults.[403]

Clatworthy and Hull have documented the poverty that most Native people in Saskatoon face. In 1983 they found that 73.8% of the Saskatoon status Indian population lived at or below the poverty line.[404] The researchers also discovered that the majority of Saskatoon's Native population is concentrated in the older core areas off the downtown area, which includes the neighborhoods of Riversdale and Pleasant Hill. The present study was conducted at the Westside Community Clinic which is located in the heart of this area on

20th st. West. Clinic staff estimate that they have a 85% Native clientele. Part of the study was also conducted at the Friendship Inn, which is next door to the clinic 20th st. West.

4.2 Survey Instrument

The survey instrument utilized in this study was an interview schedule administered by the researcher. The interview schedule was developed in cooperation with Dr. James B. Waldram of the Department of Native Studies at the University of Saskatchewan as part of a much larger research project designed to examine the utilization of the Western and traditional health care systems by the Saskatoon Native population and barriers to health care faced by this population. As part of the overall project, non-native respondents were also interviewed in order to determine their utilization of the Western health care system.The interview schedule itself consisted of one hundred and twenty-three questions (see Appendix A) and three supplemental forms (see Appendices B,C,and D) designed to elicit more detailed information on various aspects of health care utilization. As can be seen on the interview schedule, the supplemental forms were utilized when a respondent had more than one incident of hospitalization, emergency room visit, or visit to a traditional healer in the past year. Both open and close-ended questions

were utilized in an effort to produce a survey instrument which would elicit a wide range of data. As Stoner has argued, the study of the utilization of health care systems among a population is best achieved through the use of both qualitative and quantitative data.[405] The instrument was also designed to elicit a good deal of information from each respondent. Respondents signed a consent form at the end of the interview allowing the researcher to obtain data regarding the reason for their visit, diagnosis, and treatment on the day of the interview (see example of form in Appendix E).

The resulting survey instrument generally took between twenty minutes (when no supplemental forms were completed) to forty minutes (in cases where one or more supplemental forms were completed). On the basis of a pre-test, two questions eliciting little information from respondents were removed and one question which caused some comprehension problems was revised. Also, several questions on the utilization of traditional health care systems were added to elicit more information in this area. Overall, however, very few changes were made to the final interview schedule. The interview schedule proved to be an effective survey instrument, being both concise yet eliciting a significant amount of information from each subject.

4.3 Testing

A sampling frame for the Native population of Saskatoon does not exist; thus a random sampling technique could not be utilized. The study utilized a non-random sampling design, using an availability sampling technique. While a random sampling design is preferable, it can have one serious drawback as pointed out by Fuchs and Bashshur in their study on the utilization of traditional health care systems by an American Indian population: namely, a high non-response rate because not all those respondents selected for the sample can always be interviewed as many may have moved and can not be located. This, of course, introduces bias into the final sample.[406] While the present study utilized a non-random sampling design, virtually every respondent identified was interviewed thus ensuring a relatively large sample.

A pre-test was begun on October 13, 1987 at Saskatoon's main Community Clinic to avoid overlap with respondents at the Westside Community Clinic. The pre-test consisted of twelve Native and eight non-Native interviews (the non-Native interviews were part of the overall study on native and non-Native utilization of the western health care system). The pre-test was aimed at determining the average length of the interview, and also whether any problems appeared to exist with the respondents' comprehension of

questions. Two other important objectives of the pre-test were to determine if communication problems appeared to exist between a non-Native interviewer and Native respondents, and also whether Native respondents would discuss traditional medicine with the interviewer. Fuchs and Bashshur reported negative reactions by members of the Indian community to their attempts to elicit information on attitudes toward traditional health care systems from Native respondents, with some individuals indicating that discussing Indian medicine would damage its power.[407] During the pre-test the researcher approached people directly in the clinic's four waiting rooms, introducing the project briefly and then allowing them to read an introductory letter. Patients who were interested in participating in the study were interviewed after they had seen the doctor. Respondents were given three dollars for their participation in the study. Interviewing took place at the main Community Clinic from October 13-20, 1987.

Because of the relatively small percentage of Native patients seen at the main Community Clinic, the decision was made to shift the pre-test to the Westside Clinic in order to obtain the remaining Native interviews. While it would have been preferable to conduct all of the interviews for the pre-test at the main Community Clinic, time constraints did not allow

this. None of the patients interviewed for the pre-test were interviewed for the main part of the study. Interviewing for the pre-test took place at the Westside Clinic from October 21-29, 1987. The researcher did not approach the patients directly in the Westside Clinic's waiting room because the clinic aide preferred to approach the patients herself and introduce the study to them. This method worked very well, with most of the patients coming to the clinic agreeing to be interviewed. No communication problems appeared to exist between the researcher and the Native respondents. Further, all of the Native respondents in the pre-test were quite willing to discuss their utilization of and beliefs about traditional health care systems.

On November 16, 1987, testing for the main part of the study began at the Westside Clinic. The clinic aide identified respondents in the clinic's waiting room as was the case in the pre-test, and she briefly identified the purpose of the study to them. The researcher explained the study in more detail to any respondents who desired more information. A number of respondents did want more information on the purpose of the study and under whose auspices it was operating.

Each respondent was paid five dollars for his/her participation in the study. The interviewing took place in the clinic's staff/meeting room, which afforded the

researcher and respondents both privacy and a comfortable, informal atmosphere. Each respondent was interviewed alone, except when they had children with them. Every attempt was made to conduct each interview in a relaxed manner so that respondents would feel at ease discussing their beliefs on traditional health care systems. Before beginning the section of the interview schedule which dealt with utilization of traditional health care systems, a short pre-amble was read to each of the respondents to indicate why the researcher was asking them about Indian medicine and also to reassure them that they would not be asked to reveal any of the secrets of Indian medicine (see beginning of Part 3 of interview schedule for preamble). As was the case with the pre-test, the patients freely dicussed their beliefs about and utilization of traditional health care systems.

It must be made clear that while a relaxed interview was a major priority, this was not at the expense of abandoning the structure of the interview schedule. Rather, the format of the interview schedule was followed; however, if a respondent wished to discuss a particular topic further this was done, or if a respondent began to discuss their beliefs about traditional medicine before the researcher had reached this section of the interview schedule (which happened occasionally) the researcher moved to this section of

the schedule and then returned to the previous sections. No attempt was ever made to put a time limit on the interviews and respondents were allowed to discuss any topic at length because it was felt that this would yield better qualitative data by establishing a friendly relationship between the researcher and the respondents.

Interviewing continued until December 18, 1987 and then concluded for two weeks over the Christmas period when, according to the clinic's staff, few patients come to the clinic. Interviewing resumed again on January 4, 1988. It was originally believed that all of the non-Native interviews could be conducted at the Westside Clinic. However, because an insufficient number of non-Native patients came into the clinic to ensure the necessary sample size for the overall study of Native and non-Native utilization of the Western health care system (approximately fifty respondents) it was necessary to spend several days interviewing non-Native respondents at the Friendship Inn. This facility was chosen because it is in the same location as the clinic and, more importantly, because the Friendship Inn's clientele is demographically very similar to that of the clinic in terms of income and education levels. It also turned out to be necessary to conduct several Native interviews at the Friendship Inn because it became increasingly more difficult as the

study progressed to find patients who had not already been interviewed at the Westside Clinic. Unfortunately some information was lost when Native subjects were interviewed at the Friendship Inn: specifically, those questions relating directly to the respondent's visit that day to the clinic had to be omitted. It was still possible to elicit information from these subjects on their beliefs and utilization of traditional health care systems, however. The study concluded on January 22, 1988.

4.4 Statistical Analyses

The main statistical tests which were utilized in the data analysis for this study were frequencies, chi squares (which test randomness of distribution) and t-tests (which test the difference of means between two variables). As was discussed previously, a non-random sampling design was utilized because of the lack of a sampling frame for the Native population of Saskatoon. Nevertheless, it is still appropriate to use tests of statistical significance such as the chi square and t-test.[408] Statistical significance was defined in the study as $p<.05$. Statistical analyses were performed on the University of Saskatchewan mainframe system, utilizing the Statistical Package for the Social Sciences ($SPSS_X$) program. A total of 103 Native interviews were conducted.

CHAPTER FIVE: RESULTS

5.1 Demographics of Sample Native Population

5.1.1 Sex

Of a total of 103 interviews conducted, 62.1% were with females and 37.9% of the interviews were with males. This reflects the fact that the Westside Clinic has a higher ratio of female to male clients.

5.1.2 Age

The mean age of the respondents was 30.5 years, ranging from 17 to 61 years. The majority of the respondents (70.9%) were concentrated in the age range from 20 to 39 years, which reflects the age composition of the Westside Clinic's clientele.

5.1.3 Marital Status

The majority of the respondents were single (43.7%), while 34.0% were married (including common-law marriage), and 22.3% were divorced/widowed/separated.

5.1.4 Dependent Children

Slightly over one-half (55.3%) of the respondents reported having dependent children. The mean number of

dependent children was 2.4, with 24.6% of the respondents having one dependent child and 40.4% reporting having two.

5.1.5 Education

The mean level of formal education attained by the respondents was a grade level of 8.6. Some 7.8% of the respondents had achieved Grade 12, and only 1.9% had a post-secondary education (see Table 1).

5.1.6 Present Employment Status

Virtually all of the respondents in the study were unemployed (95.1%). Only 1.9% (n=2) were employed full-time when the interviews were conducted. Similarly, only 3.9% (n=4) of the respondents were receiving unemployment insurance, indicating that few respondents had been employed in the recent past.

5.1.7 Income Level

The mean annual income of the respondents was $7219.69. Some 68.0% of the respondents reported annual incomes of $10,000 or less (see Table 2). The majority of the respondents (78.6%) were receiving social assistance at the time of the interview.

Table 1: Education Level of Respondents

Grade Level	N	%*
0-6	16	15.5
7-9	47	45.6
10-12	38	36.9
Post-secondary	2	1.9
	103	99.0

* Percentages are rounded to one decimal place throughout this chapter.

Table 2: Annual Income Level of Respondents

Income Range	N	%
$ 0-3500	22	21.4
3501-6000	24	23.3
6001-10,000	24	23.3
10,000+	33	32.0
	103	100.0

5.1.8 Residency

Almost one-third (32.0%) of the respondents interviewed lived in the neighborhood of Riversdale which encompasses the area to the immediate south of the Westside Clinic. Most of the other respondents either lived in the neighborhood of Pleasant Hill (17.5%) which is immediately to the west of Riversdale, or Westmount (9.7%) which is immediately to the north of Riversdale. Few of the respondents (6.8%, n=7) reported living in neighborhoods on the east side of the Saskatchewan river which bisects the city.

Two-thirds of the sample either were currently renting a house (33.3%) or an apartment (33.3%), while only 1.9% (n=2) reported owning their own house. A number of respondents (15.7%) did not have their own accommodation and were living with friends or family. The population appears to be somewhat transient within the city, with over one-half (53.9%) reporting having moved within the city two or more times in the past year. The mean number of different places respondents had lived in the past year was 2.3. About one-fifth (20.4%) of the sample had lived in the city of Saskatoon for less than one year (see Table 3) and over one-half (52.5%) had lived in the city for more than five years. Almost one-quarter (23.3%) reported their home community to be other than Saskatoon.

Table 3: Number of Years Resident in Saskatoon

Number of Years*	N	%
0-1	21	20.4
2-5	28	27.2
6-10	29	28.2
11-20	20	19.4
21+	5	4.9
	103	100.1

* Note: Data reflect the total number of years in the city, not the total consecutive number of years.

5.1.9 Native Status and Cultural Background

The majority of the respondents in this study were status Indians (68.9%), 12.6% were non-status Indians, and 18.4% were Metis. There were no Inuit respondents in the study. Over one-third of the sample (34.0%) stated their cultural background as Plains Cree, 23.3% were Saulteaux, 17.5% were Northern Cree, and 16.5% were Metis (see Table 4). Well over one-half (58.3%) of the sample spoke a Native language as their first language. Three-quarters (75.7%) reported speaking at least one Native language today (see Table 5). Cree was the most commonly spoken Native language (64.0%), followed by Saulteaux (26.7%) (see Table 6). A number of respondents (14.7%, n=11) reported that they spoke a Native language "most of the time," with more (24.0%, n=18) reporting speaking a Native language "half the time" (with English spoken half the time) (see Table 7).

5.1.10 Summary

The sample population is culturally and linguistically diverse, yet is characterized by extremely high unemployment and a high level of social assistance. Corresponding to this is a low education level, a very low percentage of property ownership and high intra-city mobility.

Table 4: Cultural Background of Respondents

Cultural Group	N	%
Plains Cree	35	34.0
Saulteaux	24	23.3
Northern Cree	18	17.5
Metis	17	16.5
Dene	3	2.9
Dakota	3	2.9
Other	3	2.9
	103	100.0

Table 5: Number of Different Native Languages Spoken Today

Number of Languages	N	%
0	25	24.3
1	66	64.1
2	10	9.7
3	2	1.9
	103	100.0

Table 6: Number of Respondents Speaking a Native Language Today

Languages	N	%
Cree	48	64.0
Saulteaux	20	26.7
Dene	3	4.0
Dakota	2	2.7
Michif	1	1.3
Other	1	1.3
	75	100.0

Table 7: Frequency of Native Languages Spoken Today

Frequency	N	%
Most of the time	11	14.7
Half of the time	18	24.0
Occasionally	24	32.0
Rarely/Never	22	29.3
	75	100.0

5.2 Utilization of Traditional Health Care Systems

Assessment of a respondent's utilization of traditional health care systems was measured upon the basis of three variables: (1) visits to a traditional healer; (2) participation in a traditional healing ceremony (sweat lodge) in the past year; (3) use of traditional herbs and/or medicines in the past year (see Table 8). Basic utilization data will be presented first, followed by a discussion of respondents' experiences with traditional health care systems.

Only a very small percentage of the respondents (2.9%, n=3) had consulted with a traditional healer in the past year and in these cases the healer was seen outside of the city. All three respondents were status Indian and all felt that the healer had successfully treated their health problem. One-third (33.0%, n=34) of the respondents reported seeing a healer at some time in their lives for a health, emotional, or spiritual problem.

Interestingly, of those respondents who had never seen a traditional healer, over one-half (51.6%) said that this was either because they did not know enough about Indian medicine or did not know where to find a healer, or felt that there were no healers in the city (see Table 9). During the course of the interviews several of these respondents indicated that they

Table 8: Utilization of Traditional Health Care Systems

Consultations With Traditional Healer	N	%
Has seen healer in past year	3	2.9
Has seen healer at some time in life	34	33.0
Has seen healer for current health problem	0	0.0
Is planning to see healer for current health problem	7	6.8
Has seen only a healer for a health problem	21	20.4
Has seen both a healer and physician for same health problem	17	16.5
Participation in a Sweat (in past year)	4	3.9
Use of Traditional Medicine		
Traditional herbs/medicines	15	14.6
Sweetgrass	35	33.9

Table 9: Reasons for Never Having Seen a Traditional Healer

Reason	N	%
Do not know enough about traditional medicine	22	35.5
Do not believe in traditional medicine	11	17.7
Do not know where to find a healer	8	12.9
Traditional medicine is frightening	3	4.8
There are no healers in Saskatoon	2	3.2
Mother had bad experience with healer	1	1.6
Prefers treatment by a physician	1	1.6
Dysuria	1	1.6
Do not know/no reason	14	22.6
	62	101.5

would have been interested in consulting with a traditional healer at some point in their lives during a particular illness episode; however, they had no idea how to seek out a healer. A few (4.8%, n=3) respondents rejected traditional health care systems not because they questioned their efficacy, but rather because the power frightened them or they felt that Indian medicine was intrinsically evil. A relatively small percentage of the respondents (17.7%) completely rejected traditional health care systems, believing these systems to be based upon superstition or ineffective. Fewer status Indian respondents (14.3%) did not believe in Indian medicine, than Metis (20.0%) and non-status Indians (40.0%) (chi sq.=2.09; d.f.=2; sign.=.35).

Respondents were also asked if they had consulted with a healer for the health problem that had brought them to the clinic but none had; however, some of the respondents (6.8%) indicated that they were planning to see a healer for their current health problem. Some 16.5% of the respondents had seen <u>both</u> a healer and a Western physician for the same health problem. About one in five respondents (20.4%) had seen a healer <u>only</u> (and not a Western physician) for a specific health problem in the past (see Table 10 for breakdown of types of health problems).

Table 10: Past Health Problems For Which Only a Traditional Healer Was Consulted

Health Problem	N	%
Colds	5	23.8
Pneumonia	3	14.3
Pains in chest/side	3	14.3
Tuberculosis	2	9.5
Cannot remember (taken as child)	2	9.5
Spiritual strength	1	4.8
Headache	1	4.8
Diarrhea	1	4.8
Skin infection	1	4.8
Refused to answer	1	4.8
	21	100.2

Few of the respondents (3.9%, n=4) had participated in a sweat lodge ceremony in the past year (refer to Table 8) and in all of these cases the location of the sweat was outside of Saskatoon and the respondents were status Indian. It is surprising that so few respondents had participated in a sweat in the past year, although many of the respondents indicated that they had participated in a sweat at an earlier time in their lives (however specific data on this was not gathered). The impression garnered by this researcher was that sweats still play an important role in the lives of many of the respondents. As was noted in the literature review, traditionally sweats were central to the Plains Cree not only for curative purposes but also for ritualistic cleansing.

Many more of the respondents (14.6%) reported use of traditional herbs or medicines in the past year, while even more (33.9%) reported use of sweetgrass. Sweetgrass was treated as a traditional medicine in the study because it is predominately burnt as protection against evil spirits or to ensure good health and fortune through prayer. Two medicinal uses of sweetgrass were also noted by respondents: these being as a treatment for migraines, and as a treatment for a sore ear, with sweetgrass smoke being blown into the ear. As was indicated in the literature review, sweetgrass traditionally played a major role in Plains

Cree life, particularly for ritual cleansing prior to ceremonial participation. Clearly, sweetgrass still figures prominently today in the lives of the respondents. While some herbs and medicines were obtained from a healer, in many cases they were given to the respondents by relatives. Quite often the respondents were not aware of the name of the herb or medicine, but were able to identify it in terms of its purpose. Respondents indicated that they utilized specific roots to treat colds, for irregular heart beats and for general preventive health care, while herbs were noted as being utilized for bladder problems and kidney infections. Several respondents referred to "rat root" or "rat food," indicating that this was a root used for toothaches, colds, sore ears or bad breath.

None of the respondents made reference to the use of peyote which, as was discussed in the literature review, is quite widely utilized today among American Indian groups. The researcher has heard of the current use of peyote among specific bands in Saskatchewan but concrete information on this is not available. It could be the case that respondents in this study did not readily think of peyote as a medicine when they were asked "have you been treated with, or treated yourself with any Indian medicines or herbs?" because peyote is virtually exclusively utilized in a ceremonial context

and is not self-administered. Also, the peyote ritual is a very sacred ceremony and if a respondent had participated in such a ceremony they may not have felt it proper to indicate this. Further, respondents were not asked what ceremonies and rituals they had participated in other than sweats.

Respondents especially seemed to believe in the efficacy of traditional health care systems when they, a friend, or a relative had been successfully treated by a healer for a serious illness. This particularly was the case when a healer had enabled the patient to discontinue taking medication prescribed by a Western physician. For example, one respondent noted that his sister had been cured of tuberculosis by a healer. Two other respondents noted that their sister and cousin respectively were treated for arthritis and were able to discontinue their medication, while another respondent reported that both his uncle and cousin were successfully treated by a healer for paralysis affecting one entire side of their bodies. Another respondent stated that her diabetic aunt no longer had to have insulin shots after she had consulted with a healer, and also that her mother was able to discontinue her heart medication after seeing a healer.

One respondent noted that a friend who "couldn't think straight" went to a healer and was immediately cured. Another respondent, who believed strongly in

"bad medicine," told of both her mother and father's experiences with "bad medicine" and their subsequent curing by a healer:

> The respondent's mother had had a recurring problem with her leg in which the leg would swell up above the knee and become very painful. Physicians had been unable to diagnose the cause of this condition and so the respondent accompanied her mother to a healer. The healer wrapped the woman's leg in a birch bark cast which had herbal medicines inside it. After several days the healer took the cast off and wrapped the leg in a clean white cloth. The next day he removed the cloth and revealed the source of her illness: a human hair approximately one foot long had appeared on the inside of the cloth, having come out of the woman's leg. The respondent's mother then fully recovered. The respondent's father had also encountered "bad medicine" or, more specifically, love medicine. Her father had been given a beautiful beaded jacket by a woman; however, whenever he wore the jacket he became very disoriented and would keep appearing unexpectedly at this woman's community which was some distance from his own. The respondent's father eventually visited a healer who discovered that the woman had sewn love medicine into the jacket's sleeve, which had resulted in the man being under this woman's love spell. The jacket was burned, the man was treated with herbal medicines, and he recovered soon after [from notes taken by interviewer; respondent gave permission to interviewer to use this information].

As was discussed in the literature review, disease-object intrusion, a form of "bad medicine," traditionally was a predominant disease etiology on the Plains.

Other respondents who believed in traditional medicine told of their own successful experiences with healers. In another case of "bad medicine," a respondent noted that a healer had rubbed his hands over the respondent's leg and removed a hair from

inside the leg. The healer then sent the "bad medicine" back to the person who had sent it. Another respondent, who had seen a healer within the past year, noted that the healer had performed a sucking technique on her right lower abdomen and had removed a rabbit's knee. As was pointed out in the literature review, the sucking technique was frequently used in cases of disease-object intrusion.

One respondent, who had also seen a healer in the past year for back pain, was diagnosed as suffering from the pain because her father had broken a taboo. Her father had fallen from a horse, but his pain was passed on to his daughter because of the broken taboo. This is a classic "sins of the father" disease etiology in which the sin, or punishment for a broken taboo, of ancestors or parents is passed on to the descendent, causing illness or disease. As was noted in the literature review, this disease etiology was also traditionally found on the Plains. Another respondent who visited a healer for a pain in his chest was diagnosed as having an evil spirit in his body. The healer gave the respondent a decoction and then exorcised the evil spirit from the respondent's body. The respondent noted that his chest pains were gone the next day. Interestingly, the disease etiology of spirit intrusion was traditionally not found on the Plains,

but rather was more common among Inuit groups and in the Plateau region.

5.3 Access to Traditional Health Care Systems in the Urban Centre

The second major aim of this research was to determine if the Native population of Saskatoon wants access to traditional Indian medicines and healers within the Western health care system.

Few respondents (5.8%, n=6) reported knowing of a practicing healer in the city. For purposes of the interview schedule, respondents were asked whether they would like Indian medicines and Indian "doctors" available at the Westside Clinic (however, respondents interviewed at the Friendship Inn were simply asked if they would like access to Indian medicines and/or a healer within the city). Traditional healers were referred to as "Indian doctors" on the interview schedule because Indian elders consulted during the construction of the schedule indicated that this was the most commonly used term among Native people. Well over one-half (58.9%) of the respondents indicated that they would like Indian medicines and a healer available at a clinic. Even more respondents (64.4%) indicated that they would actually consult with an Indian doctor if one were available at a clinic. Of those who wanted Indian medicines available at a clinic, almost one-half

(47.9%) stated that this was because they had a strong belief in the power of Indian medicine and/or they had experienced its healing powers firsthand or knew of a relative or friend who had been cured by a healer (see Table 11). One-third (33.3%) of the respondents wanted Indian medicines/healer available because they wantedto learn about it or wanted the opportunity to experience it. Some of the respondents (12.1%) felt it would not be appropriate for either Indian medicines or a healer to be available at a clinic because traditional medicine should be kept confidential and in its own environment, such as on a reserve (see Table 12).

Respondents who indicated they would actually consult with a healer if one were available at a clinic were asked why they would see a healer (see Table 13). Two-thirds (66.6%) of the respondents who indicated that they would consult with a healer stated a medical reason, ranging from colds, general bodily aches and pains, headaches, and fever to diabetes, stomach and kidney problems, cancers and terminal conditions. Thus it would seem that many of the respondents see healers as able to treat a wide range of physical illnesses, including more serious conditions. A number (21.1%) of respondents also indicated that they would consult with a healer for personal and/or spiritual problems, with several (12.3%) indicating that they would see a healer for all kinds of illnesses.

Table 11: Major Reasons Why Respondents Wanted Traditional Medicines/Healer Available at a Clinic

Reason	N*	%
Believe in traditional medicine	23	47.9
Want to learn about traditional medicine	16	33.3
Part of cultural background	3	6.2
New experience	2	4.2
Would benefit Native patients	2	4.2
To get treatment for specific health problem	2	4.2
	48	100.0

* Reflects number of responses, not respondents. Some respondents could not state a reason why they wanted traditional medicines/healer available at the clinic and others gave multiple reasons.

Table 12: Major Reasons Why Respondents Did Not Want Traditional Medicines/Healer Available at a Clinic

Reason	N*	%
Do not believe in traditional medicine	13	39.4
Do not know enough about traditional medicine	7	21.2
Do not trust healers/ traditional medicine evil	5	15.2
"White" medicine sufficient/superior	4	12.1
Not appropriate in clinic	4	12.1
	33	100.0

*Reflects number of responses, not respondents. Some respondents could not state a reason why they did not want traditional medicines/healer available at the clinic, and others gave multiple reasons.

Table 13: Proposed Reasons for Consultation With a Traditional Healer at a Clinic

Health Problem	N*	%
Personal/spiritual problems	12	21.1
Colds, lung problems	8	14.0
All illnesses	7	12.3
To learn about traditional medicine	5	8.8
Terminal conditions/ cancers	4	7.0
Infections	3	5.3
Headaches	3	5.3
Kidney problems	2	3.5
Bodily aches/arthritis	2	3.5
Infertility	2	3.5
Stomach problems	2	3.5
Other	7	12.2
	57	100.0

*Reflects number of responses, not respondents; several respondents stated multiple health problems for which they would consult a healer.

5.4 Interaction Between the Western and Traditional Health Care Systems

It appears that use of traditional health care systems is maintained in addition to utilization of the Western health care system. Use of traditional health care systems was not found to detract from use of the Western health care system, as measured by such variables as whether the respondent had a family doctor, whether the respondent had a regular dentist, and the last time the respondent visited his family doctor, (see Table 14 in Appendix F). In fact, a significantly higher percentage of those respondents who had seen a healer at some time in their lives had a regular dentist (55.9%) as compared to those who had never seen a healer but had a regular dentist (28.8%) (chi sq.=5.88; d.f.=1; sign.=0.01). Also, a greater percentage of respondents who had seen both a healer and a physician for the same health problem had a regular dentist (58.8%) compared to those who had not seen a healer and a physician for a health problem but had a regular dentist (32.9%) (chi sq.=2.97; d.f.=1; sign.=0.08).

Well over one-half (61.1%) of the respondents stated that they believed that traditional healers could treat certain health problems better than Western physicians (see Table 15 for breakdown of types

Table 15: Health Problems Traditional Healers Can Treat Better Than Physicians

Health Problem	N*	%
Illness from "bad medicine"	17	29.8
Terminal illness/cancer	9	15.8
Personal/spiritual problems	6	10.5
Colds	4	7.0
Most/all illness	4	7.0
Heart/liver/kidney/ stomach problems	4	7.0
Diabetes	2	3.5
Arthritis	2	3.5
Paralysis	2	3.5
Other	7	12.2
	57	99.8

*Reflects number of responses, not respondents; a number of respondents gave multiple responses and several could not give a specific example of a health problem.

of health problems). More respondents who learned a Native language as their first language felt that traditional healers could treat some health problems better (63.5%) as compared to English first language speakers (57.9%) (chi sq.=0.09; d.f=1; sign.=0.75). Among current Native language speakers, a higher percentage stated that traditional healers could treat some health problems better (65.7%) as compared to English-only speakers (47.8%) (chi sq.=1.60; d.f.=1; sign.=0.20). The most frequently cited health problem for which a person sought a healer (29.8%) was illness resulting from "bad medicine". A number of respondents (15.8%) felt that healers were able to treat terminal illnesses and cancer better than physicians. Healers were also seen as being better able to treat a variety of other physicial illnesses and conditions, including psoriasis, sterility, colds, headaches, arthritis, paralysis, diabetes, and heart, liver and stomach problems. Healers were also seen by a few (10.5%, n=6) as being better able to counsel those with personal or spiritual problems compared to physicians. Interestingly, several respondents (7.0%, n=4) felt that healers could treat most or all illnesses better than physicians.

Even more respondents (84.3%) stated that physicians could treat certain health problems better than traditional healers (see Table 16 for a breakdown

Table 16: Health Problems Physicians Can Treat Better Than Traditional Healers

Health Problem	N*	%
Most/all illness	21	29.2
Terminal illness/cancer	18	25.0
Conditions requiring surgery	14	19.4
Colds	4	5.6
Bone fractures	3	4.2
Conditions requiring medication	3	4.2
Tuberculosis	2	2.8
Other	7	9.6
	72	100.0

*Reflects number of responses, not respondents; a number of respondents gave multiple responses and several could not give a specific example of a health problem.

of the types of health problems). Fewer Native first language speakers (79.6%) believed that physicians could treat certain health problems better than traditional healers, as compared to English first language speakers (90.0%) (chi sq.=1.10; d.f=1; sign.=0.29). Also, slightly fewer current Native language speakers (82.8%) than non-speakers (88.0%) stated that physicans could treat some health problems better than traditional healers (chi sq.=0.07; d.f.=1; 0.77). Most of the respondents (29.2%) indicated that physicians were superior to healers in treating most or all illness. One-quarter (25.0%) of the respondents stated that physicians could treat terminal illnesses and cancer better than healers, and a number of respondents (19.4%) felt that physicians were superior to healers in cases requiring surgery. Physicians were seen as better able to treat several other physical illnesses and conditions, including colds, bone fractures and tuberculosis.

Thus traditional healers and physicians are both seen as being able to treat a wide range of physical illnesses, including serious illnesses. Healers, however, were seen as being able to treat those with personal or spiritual problems while physicians were not noted as being effective in this area.

A number of respondents (16.5%, n=17) reported that they had utilized both traditional and Western health care systems for the same illness episode (see Table 17 for breakdown of types of health problems). In most of the cases (76.5%, n=13) a traditional healer was consulted after the respondent had been to a physician but felt that he/she had not been "cured." In two cases, respondents had taken their child to a healer after consulting with a physician regarding their child's illness. The respondents were asked how much time had elapsed between their visit to the physician and the subsequent visit to the healer; however, often the respondents could not be specific in terms of the exact length of time but were able to indicate if it was within the same year. In most cases, (76.9%) the visit to the physician was followed by a visit to a healer, and in two cases healers were consulted within days of the visit to the physician. In 23.5% (n=4) of the cases where respondents had seen both a traditional healer and a physician for the same problem, the healer was consulted first, followed by a visit to a physician. The majority (64.7%) of the consultations with healers (seen either first or after consultation with a physician) occurred in 1980 or after, and over

Table 17: Health Problems[1] For Which Respondent Saw Both a Traditional Healer and Physician

Health Problem	N	%
Swollen foot/leg	3	17.6
Depression/emotional breakdown	2	11.8
Took child (colic; fever)	2	11.8
Cold/sore throat	2	11.8
Diabetes	1	5.9
Kidney Problems	1	5.9
Back pain	1	5.9
Goiter	1	5.9
Cut foot	1	5.9
Hair loss	1	5.9
Inability to urinate	1	5.9
Cramps/vomiting	1	5.9
	17	100.2

[1] Health problems were usually expressed in terms of symptoms and not etiology.

one-half (52.9%) of the consultations occurred in 1985 or after, indicating that traditional health care systems are currently active. As is indicated on Table 16, the respondents' health problems ranged from a swollen foot or leg, and colds, to more serious health problems such as diabetes and kidney problems. In two cases, healers were consulted for psychological problems after an unsuccessful visit to a physician.

In a number of cases, the respondents were diagnosed as being victims of "bad medicine." One respondent reported having consulted with a physician because his leg would occasionally swell up for no apparent reason. The physician's diagnosis was arthritis, and the respondent was given pain killers. A traditional healer was consulted in the same year, who diagnosed the condition as being from "bad medicine" and provided the respondent with a herbal decoction which helped the condition.

Similarly, another respondent reported seeing a physician because her foot had become very swollen and sore while it was in a cast. The physician was unable to diagnose the cause of the problem and prescribed pain killers. The foot remained problematic so a healer was consulted within the same year. The healer diagnosed the cause of the illness as "bad medicine:" specifically, the respondent had poison in her blood or "black blood." The healer made small incisions in the

respondent's foot and applied medicine to the area which the respondent said alleviated her condition. As was discussed in the literature review, traditionally the use of incisions and the application of medicine directly to them was another commonly used technique in cases of disease-object intrusion.

Another respondent had gone to a physician complaining of stomach cramps, blurred vision and vomiting. According to the respondent, the physician could not determine the cause of her illness. The same week she visited a healer who told her that the illness had occurred because someone had done "bad stuff" to her. The healer gave the respondent a small leather pouch containing medicines to wear under her clothes against her heart. The respondent reported that she was better within two days of seeing the healer.

Emotional and psychological problems can also be diagnosed by healers as being the result of "bad medicine." One respondent related her experience: she had been diagnosed as having suffered an emotional breakdown and was placed on a psychiatric ward. Later that same year she visited a healer who diagnosed her condition as resulting from "bad medicine." The respondent was covered with a blanket under which the healer placed a heated stone annointed with medicine. This would be similar to the effect obtained by participation in a sweat: namely, the patient's body

and spirit are purified and strengthened. Another respondent who was diagnosed as suffering from depression visited a psychologist without success. The respondent subsequently visited a healer the same month who diagnosed him as needing to restore the harmony in his body through a sweat. In both these cases, the respondents felt that they had received significant psychological benefits from their encounters with traditional health care systems.

Two respondents reported a negative experience in their visit to a healer. The first respondent had seen a healer for a sore throat and cough and was given a herbal medicine. She then became quite ill so she visited a physician within a few days of her visit to the healer. The physician subsequently placed the respondent in the hospital. The respondent now blames the healer for not properly diagnosing her illness, and she has completely rejected traditional health care systems. The second respondent who reported a negative experience was a diabetic who was being treated with insulin and had been placed on a special diet. She saw a healer later the same year because she had heard that they could cure diabetes. The healer gave her a decoction and a dry form of the medicine which she was to take home and mix with water. The healer also told her to discontinue her insulin shots, which she did for one year. She subsequently became very ill and saw a

physician who placed her back on insulin treatments. This respondent now, understandably, feels that Indian medicine is "dangerous." Generally, however, respondents reported their encounters with healers to be very successful.

5.5 Hypotheses

In the course of this research project four hypotheses were tested.

5.5.1 Hypothesis One

> Socio-cultural variables will be significantly more important than socio-economic variables in predicting utilization of traditional health care systems by Native respondents.

A number of socio-cultural and socio-economic variables were examined to determine their relationship, if any, to utilization of traditional health care systems (see Table 18 in Appendix G). Socio-cultural variables examined included the first language the respondent learned to speak (Native or English), the language(s) the respondent speaks today, and the age of the respondent. Age was included as a socio-cultural variable because it was felt that older respondents would be more likely than younger respondents to retain traditional beliefs concerning health and health care.

Language appears to be a somewhat useful predictor of utilization of traditional health care systems. Some 37.9% of those respondents whose first spoken language was a Native one reported seeing a traditional healer at some point in their life, as compared to 27.9% who learned English as their first language (chi sq.=0.71; d.f.=1; sign.=0.40). Of those speaking a Native language today, 39.7% had seen a healer at some time, as compared to 17.9% who spoke only English and who had seen a healer (chi sq.=3.41; d.f=1; sign.=0.06). Little difference existed, however, between those speaking their Native language today "rarely or never" who reported seeing a healer at some time (36.4%) and those speaking their Native language "most of the time" and had seen a healer (31.8%) (chi sq.=1.01; d.f.=3; sign.=0.79). It could be concluded that language retention is more important than actual use of a Native language when attempting to predict consultations with a traditional healer.

Similar patterns, although none statistically significant, were revealed for respondents who reported seeing a traditional healer only (and not a physician) for a specific health problem. Of those respondents speaking a Native language as their first language, 21.2% had seen only a healer, while 17.5% of English first language speakers had seen only a healer (chi sq.=0.03; d.f.=1; sign.=0.86) Of those speaking a

Native language today, 22.2% had seen only a healer, while 12.0% of those speaking only English had seen only a healer (chi sq.=0.66; d.f.=1; sign.=0.41). More respondents who reported speaking a Native language "most of the time" (18.2%) had seen only a healer, while 9.1% of those speaking their Native language "rarely or never" had seen only a healer (chi sq.=4.12; d.f.=3; sign.=0.24).

Some 19.3% of respondents speaking a Native language as their first language had seen both a healer and a physician for the same health problem, as compared to 15.0% of those speaking English first (chi sq.=0.07; d.f.=1; sign.=0.78). Of those speaking a Native language today, 19.4% had seen both a healer and a physician, as compared to 12.0% among those who speak only English. No difference existed between those who spoke their Native language "most of the time" (18.2%) and those speaking their Native language "rarely or never" (18.2%) (chi sq.=0.46; d.f.=3; sign.=0.92). Thus again it would appear that language retention is more important than actual language use in determining utilization of traditional health care systems.

Slightly fewer respondents who were Native first language speakers reported use of traditional herbs (49.2%) compared to English first language speakers (51.2%) who used herbs (chi sq.=0.00; d.f.=1;

sign.=1.00). However, more respondents who spoke a Native language today reported use of herbs (52.1%) compared to English language speakers who used herbs (44.4%) (chi sq.=0.20; d.f.=1; sign.=0.65). More respondents who spoke their Native language "rarely or never" reported use of herbs (61.9%) as compared to those speaking it "most of the time" (45.5%) (chi sq.=1.45; d.f.=3; sign.=.691). Again, it can be surmised that language retention appears to be more important than actual language use.

Age was not found to be related to utilization of traditional health care systems. The mean age of respondents who had seen a healer at some time was 31.9 years, while the mean age of those never having seen a healer was 29.7 years (T=1.11; d.f.=86; prob.=0.27). Virtually no difference existed between the mean age of those who had used herbs (29.3 years) and those who had not (29.7 years) (T=-0.11; d.f.=48; prob.=0.91). The mean age of those who had seen only a healer for a health problem was 32.3 years, and the mean age of those who had never seen only a healer for a health problem was 30.4 years (T=0.71; d.f.=95; prob.=0.48). Similarly, there was only a slight difference between the mean age of those respondents who had seen both a healer and a physician for the same health problem (32.6 years) and those who had not (30.4 years) (T=0.81; d.f.=95; prob.=0.42).

Several socio-economic variables were also examined, including mean income and mean education level. A significant difference existed between the mean annual incomes of those respondents who had seen a traditional healer at some time in their life ($8462) and those who had not ($6607) (T=2.09; d.f.=96; prob.=0.03). No significant difference existed between the annual income of those respondents who had used herbs ($7056) and those who had not ($7535) (T=-0.55; d.f.=94; prob.=0.58). Also, no significant difference existed between respondents who had seen only a healer for a health problem ($8266) and those who had not ($7015) (T=1.16; d.f.=93; prob.=0.24), or between those who had seen both a healer and a physician for the same health problem ($8717) and those who had not ($6949) (T=1.58; d.f.=93; prob.=0.12). A significant difference almost existed between the mean grade level of those respondents who had seen a healer at some time in their life (9.3 years) and those who had never seen a healer (8.3 years) (T=1.90; d.f.=49; prob.=0.06). No difference existed between the grade level of those respondents who reported use of herbs (8.7 years) and those who had not (8.5 years) (T=-0.34; d.f.=98; prob.=0.74). Likewise, no significant difference existed between the mean education level of those respondents who had seen both a healer and a physician for the same health problem (8.8 years) and those who

had not (8.5 years) (T=0.59; d.f.=95; prob.=0.56). However, a significant difference did exist between the mean education level of those who had seen only a healer for a health problem (9.7 years) and those who had not (8.3 years) (T=2.33; d.f.=95; prob.=0.02).

In conclusion, it would appear that language is a moderately good predictor of utilization of traditional health care systems. This was found to exist both in terms of Native first language speakers and current Native language speakers, although it does appear that the actual use of a Native language is not related to use of traditional health care systems. Rather, language retention (the ability to speak a Native language) appears to be somewhat related to the respondents' utilization of traditional health care systems. The last socio-cultural variable, that of mean age, was not found to be related to utilization, although the respondents who utilized traditional health care systems were generally slightly older than those not utilizing these systems. The socio-economic variables of annual income and education level were found to be significantly related to utilization, although it must be emphasized that the income level of respondents was basically very low for all the respondents as was the mean education level achieved. Generally, both the income and education level was higher for those respondents utilizing traditional

health care systems. In conclusion, hypothesis one must be rejected because socio-cultural variables were not found to be more important than socio-economic variables in utilization of traditional health care systems.

5.5.2 Hypothesis Two

> Those respondents with Indian status will be significantly more likely than those without Indian status to utilize traditional health care systems.

This hypothesis is based upon the assumption that because of their connection with a reserve, status Indian respondents would have greater knowledge of and access to traditional health care systems than respondents without Indian status (non-status Indian and Metis).

A significant difference was found to exist between those respondents with Indian status and those without Indian status in terms of the use of medicinal herbs (see Table 19 in Appendix H). While 57.1% of the respondents with Indian status reported use of herbs, 33.3% of those without Indian status reported use of herbs (chi sq.=3.85; d.f.=1; sign.=0.04). No other significant differences existed between respondents with Indian status and those without Indian status on the other measures of utilization of traditional health care systems.

Also, when each group was examined individually, differences were apparent. Interestingly, the category reporting the largest proportion of respondents having seen a traditional healer at some time was that of non-status Indian (61.5%), with approximately one-third (33.8%) of status Indians reporting having seen a healer, and slightly over 10% (11.8%) of Metis reporting seeing a healer. These inter-group differences were found to be statistically significant (chi sq.=8.17; d.f.=2; sign.=0.01). Significant differences were also found to exist between the three groups in terms of respondents reporting having seen a healer only for a specific health problem, with non-status Indians again having the largest proportion at 46.2%; followed by status Indians at 17.6% and Metis at 6.3% (chi sq.=7.79; d.f.=2; sign.=0.02). It could be the case that few cultural differences exist between non-status and status Indians. This assumption is supported when one compares the two groups on the variables of first language spoken with 62.0% of status Indian respondents being Native first language speakers, compared to 61.5% of non-status Indian respondents (chi sq.=0.00; d.f.=1; sign.=1.00). Also, no significant difference existed between the two groups in terms of languages spoken today, with 78.9% of status Indian respondents speaking a Native language today, compared to 76.9% of non-status Indian

respondents (chi sq.=0.00; d.f.=1; sign.=1.00. Indeed, as Waldram has pointed out, it is not always appropriate to assume that the legal distinction between status and non-status Indians translates to a cultural distinction between the groups. Rather, it could be the case that the cultural affinity of a group or an individual is paramount in determining social relations and, in this case, utilization of traditional health care systems.[409]

Status Indians reported the greatest use of herbs (57.1%) as compared to non-status Indian (16.7%) and Metis (44.4%) respondents (chi sq.=6.98; d.f.=2; sign.=0.03). No significant difference existed between the groups in terms of seeing <u>both</u> a physician and a healer for the same health problem: status Indian =20.6%; non-status Indian=15.4%; Metis=6.3% (chi sq.=1.88; d.f.=2; sign.=0.38).

In conclusion, Indian status by itself is not a particularly good predictor of utilization behavior; thus, hypothesis two must be rejected. This may be due largely to the inappropriateness of the legal distinction between status and non-status Indians in a cultural analysis of this type. In other words, some non-status Indian respondents may have strong cultural ties to traditional Indian culture while others may not identify with this culture, and some status Indian

respondents may have close ties to traditional culture while others may not.

5.5.3 Hypothesis Three

> Respondents who have experienced difficulty utilizing the Western health care system will be significantly more likely to utilize traditional health care systems than respondents who have not experienced this difficulty.

A number of variables were used to measure difficulty utilizing the Western health care system, including language, cultural and economic barriers (see Table 20 in Appendix I). Variables measuring language and cultural problems were as follows: difficulty finding a doctor (or nurse) or making an appointment with a doctor; difficulty explaining a health problem to a doctor (or nurse); difficulty understanding the language used by the doctor (or nurse), or understanding a doctor's instructions concerning a health problem, or difficulty understanding the doctor's directions for taking prescribed medication. Respondents were also asked if they had ever been treated by a doctor (or nurse) in a way that made them "feel bad," or if they had ever been denied medical care by health care providers. Variables measuring economic problems included difficulty travelling to see a doctor or nurse, difficulty paying for a babysitter so they could visit a doctor, difficulty paying for

prescription drugs, or difficulty paying for non-prescription drugs and other medicines.

In terms of possible language and cultural problems which could act as barriers to maximum utilization of the Western health care system, 17.5% of the respondents reported difficulty finding a doctor at some time in their life, 21.6% reported difficulty making an appointment with a doctor at some time, while 26.2% reported difficulty explaining their health problem to a doctor at some time. While 9.6% of those who reported difficulty explaining a health problem to a doctor spoke a Native language today, 4.8% of those reporting this difficulty spoke only English (chi sq.=0.04; d.f.=1; sign.=0.83). Almost half of the respondents (46.1%) reported having difficulty at some time understanding a doctor's language. Little difference existed between respondents who reported difficulty understanding a doctor's language and spoke a Native language today (47.3%), and those respondents who experienced this difficulty but spoke only English (42.9%) (chi sq.=0.03; d.f.=1; sign.=0.85). Over one-quarter of the respondents (26.2%) experienced difficulty at some time understanding a doctor's instructions concerning a health problem. Slightly fewer of those reporting this difficulty were current Native language speakers (25.7%) as compared to those reporting this difficulty and speaking only English

(27.6%) (chi sq.=0.00; d.f.=1; sign.=1.00). Some 15.5% of the respondents had difficulty at some time understanding a doctor's directions for taking prescribed medication. While 14.9% of those respondents reporting difficulty understanding a doctor's directions spoke a Native language today, 17.2% reporting this difficulty spoke only English (chi sq.=0.00; d.f.=1; sign.=1.00).

Some 7.9% (N=8) of the sample reported being turned away from medical care at some time. Little difference existed between respondents who reported being turned away from medical care and who were current Native language speakers (8.2%) and those who were turned away but were English-only speakers (7.1%)(chi sq.=0.00; d.f.=1; sign.=1.00). Some 22.9% of the respondents reported having been treated at some time by a doctor or nurse in a manner which made them "feel bad." Fewer respondents who were made to "feel bad" at some time were current Native language speakers (18.8%), as compared to those reporting this difficulty but speaking only English (33.3%) (chi sq.=1.55; d.f.=1; sign.=0.21). When respondents were asked why they felt the doctor or nurse had treated them in this manner many felt that it was because of the personality of the health care provider: "He (doctor) was a grouch;" "She (nurse) was bitchy to everyone;" "She (nurse) was maybe in a bad mood." A number of the respondents blamed

themselves for the incident: "I was drinking. It was my fault;" "I was on medication for asthma and was cranky;" "I missed the appointment so I guess I deserved it." Only three respondents (7.3% of those who reported being treated in a way that made them "feel bad") suggested that the incident was the direct result of racism on the part of the health care provider: "Nurses don't like Indians;" "Because I'm Native;" "She (nurse) seemed prejudiced."

Difficulties finding a doctor or making an appointment with a doctor were not found to be related to utilization of traditional health care systems. For example, of the respondents who reported difficulty at some time finding a doctor, 27.8% had seen a healer at some time, as compared to 34.9% not experiencing this difficulty but having seen a healer (chi sq.=0.09; d.f.=1; sign.=0.75). Similarly, difficulty explaining a health problem to a doctor was not related to utilization of traditional health care systems, with 26.9% of those who experienced this difficulty having seen a healer as compared to 36.0% not experiencing this difficulty but having seen a healer (chi sq.=0.36; d.f.=1; sign.=0.54). Difficulty understanding a doctor's instructions concerning a health problem was found to be related to whether a respondent had seen <u>only</u> a healer for a health problem, with 34.6% of respondents who indicated they had experienced problems

understanding a doctor's instructions also reporting having seen only a healer for a health problem as compared to 14.1% who reported no problems and had seen only a healer (chi sq.=3.87; d.f.=1; sign.=0.04). Difficulty understanding a doctor's instructions was not found to be related to any other variables measuring utilization of traditional health care systems, however. Respondents who had experienced difficulty understanding a doctor's directions for taking prescribed medication were also more likely to have seen only a healer for a health problem, with 40.0% of those reporting such difficulties having seen only a healer compared to 15.9% of those reporting no difficulties but having seen a healer (chi sq.=3.28; d.f.=1; sign.=0.06).

The last two variables measuring language and cultural barriers, being treated in a way that made the respondent "feel bad" or having ever been turned away from receiving medical care, were not found to be related to utilization of traditional health care systems. For example, 36.4% of those who reported being made to "feel bad" had also seen a healer at some time, as compared to 30.1% who had never been made to "feel bad" but had seen a healer (chi sq.=0.08; d.f.=1; sign.=0.77); and 25.0% of those reporting having been turned away from medical care had seen a healer at some time, compared to 34.1% who had never been turned away

but had seen a healer (chi sq.=0.01; d.f.=1; sign.=0.89).

There is evidence that some of the respondents in the study suffered economic problems when attempting to utilize the Western health care system. Many of the respondents (41.7%) reported that they occasionally had financial difficulty travelling to see a doctor at some time, especially when they had to travel across the city. This is also supported by the finding that 39.1% of the respondents stated that they had come to the Westside Clinic on the day they were interviewed because it was close to where they lived, and also that 64.1% of the respondents reported having walked to the clinic that day. Some 22.2% of the sample reported difficulty paying for a babysitter so that they could visit a doctor or take another of their children to a doctor. About one-fifth (21.4%) reported difficulty paying for prescription drugs; however, if one deletes status Indians from the analysis (who do not pay for prescription drugs) this figure increases: 53.8% of non-status and 52.6% of Metis respondents reported difficulty paying for prescription drugs. Over one-third of the respondents (37.9%) reported difficulty paying for non-prescription drugs; status Indians are not covered for these.

Some significant differences were found to exist between variables measuring socio-economic barriers and

utilization of traditional health care systems. Of those reporting having difficulty paying for prescription drugs, 40.0% had seen only a healer (and not a physician) for a health problem at some time in their life, as compared to 14.3% who had not experienced such difficulties but had seen a only a healer (chi sq.=5.13; d.f.=1; sign.=0.02). Interestingly, significantly fewer respondents who reported difficulty travelling to a doctor had seen a healer at some time in their life (20.9%) as compared to those who had not experienced this difficulty but had seen a healer (43.1%) (chi sq.=4.48; d.f.=1; sign.=0.03).

It appears that the respondents in this study do face real language, cultural and economic barriers in utilizing the Western health care system. While several of these variables are related to utilization of traditional health care systems, most are not; thus, hypothesis three is be rejected.

5.5.4 Hypothesis Four

> Respondents who are more "traditional" will be significantly more likely than "non-traditional" respondents to desire urban access to traditional health care systems.

"Traditionality" was measured in this research through a number of socio-cultural variables, including Native status (status Indian or non-status

Indian/Metis), first language spoken, language(s) spoken today, and age (see Table 21 in Appendix J). Respondents were asked two questions to determine whether they wanted urban access to traditional health care systems: firstly, did they want traditional medicines and a healer available at a city clinic (emphasis was upon the Westside Clinic); secondly, would they actually consult with a healer in a clinic if one were available. As was noted earlier, 58.9% of the respondents indicated they would like access to traditional medicines and a healer in a city clinic, and 64.4% indicated they would actually consult with a healer if one were available in a clinic. A significant difference did not exist between those respondents with Indian status (62.5%) and those without (50.0%) in terms of desired access to traditional medicines and a healer at a clinic (chi sq.=0.73; d.f.=1; sign.=0.39). Also, no significant difference existed between status Indian respondents (67.2%) and respondents without status (57.7%) in terms of the likelihood of actual consultation with a healer at a clinic (chi sq.=0.37; d.f.=1; sign.=0.54). However, more status Indian (62.5%) respondents wanted access to traditional medicines and a healer at a clinic as compared to non-status Indians (46.2%) or Metis (53.8%) respondents (chi sq.=1.35; d.f.=2; sign.=.508). Similarly, slightly more status Indian respondents (67.2%) stated that they

would actually consult with a healer at a clinic, as compared to non-status Indian (61.5%) or Metis (53.8%) respondents (chi sq.=.895; d.f.=2; sign.=.639).

One's first spoken language was not found to be significantly related to whether respondents desired access to traditional medicines and a healer at the clinic, although more respondents who spoke a Native language as their first language (67.3%) desired this access as compared to English first language speakers (47.4%) (chi sq.=2.82; d.f.=1; sign.=0.09). However, whether a respondent would actually consult with a healer at a clinic was found to be significantly related to one's first spoken language, with three-quarters (74.5%) of Native first language speakers indicating they would consult with a healer, as compared to one-half (51.3%) of English first language speakers (chi sq.=4.23; d.f.=1; sign.=0.03).

A significant difference existed between the language(s) spoken today and whether respondents wanted access to traditional medicines and a healer at a clinic, with 68.2% of those speaking a Native language today wanting this access, as compared to 33.3% of those who do not speak a Native language (chi sq.=7.44; d.f.=1; sign.=0.006). Of those speaking a Native language "most of the time," 77.8% stated they would like access to traditional medicines and a healer at a clinic, compared to 63.6% of those speaking their

Native language "rarely or never" (chi sq.=1.53; d.f.=3; sign.=0.67). A significant difference also existed between those speaking a Native language today who stated that they would actually visit a healer at a clinic (73.8%) as compared to those not speaking a Native language (40.0%) (chi sq.=7.61; d.f.=1; sign.=0.005). Some 88.9% of those speaking their Native language "most of the time" reported that they would consult with a healer, as compared to 68.2% of those speaking their Native language "rarely or never" (chi sq.=2.46; d.f.=3; sign.=0.48). Thus language seems to be somewhat important in predicting whether respondents wanted access to traditional medicines and a healer at a clinic, and also whether they would actually consult with a healer if one were available at a clinic. While the actual use of a Native language was not found to be related to desired access to a healer and traditional medicines, and whether a healer would actually be consulted at a clinic, the ability to speak a Native language was found to be related.

There was a significant difference between the mean age of those respondents who desired access to traditional Indian medicines and a healer at a clinic (28.1 years) and those who did not desire this access (32.9 years) (T=-2.16; d.f.=60; prob.=0.03). However, this is contrary to what was hypothesized as it was assumed that the older a Native respondent was the more

likely he/she would be to desire access to traditional systems because he/she would be more "traditional" in terms of ties to Native cultures. Similarly, there was a significant difference between the mean ages of respondents who stated that they would actually consult with a healer at a clinic (28.1 years) and those who would not consult with a healer (33.6 years) (T=-2.23; d.f.=46; prob.=0.03). Perhaps younger Native respondents want urban access to traditional medicines and healers in order that they can learn about traditional health care systems. As was noted in the discussion of hypothesis one, it was found that those respondents utilizing traditional health care systems generally had a mean age slightly higher than those not utilizing these systems. Alternatively, it could be the case that the younger respondents had more recently come from a reserve or rural area where they had encounters with traditional systems. This supposition is supported by the finding that those respondents desiring access to traditional medicines and a healer at the clinic had lived in Saskatoon fewer mean years (5.8 years) as compared to those who did not desire this access (11.0 years) (T=-1.82; d.f.=40; prob.=0.07). Similarly, those respondents who stated that they would actually consult with a healer at a clinic had lived in Saskatoon fewer mean years (6.4 years) compared to those who would not consult with a

healer (10.3 years) (T=-1.23; d.f.=36; prob.=0.22). A significant relationship did not exist, however, between the respondents' ages and the number of years they had lived in the city (r=.137; sign.=0.08).

In conclusion, a significant difference was not found to exist between those respondents with Indian status and those without Indian status in terms of desired access to traditional health care systems. A significant difference did exist between respondents who were Native first language speakers and those who were English first language speakers in terms of whether they would actually consult with a healer at a clinic. A significant difference also existed between respondents speaking a Native language today and those speaking only English and desired access to a healer and traditional medicines at a clinic, and also whether a healer would actually be consulted at a clinic. However, as was the case with hypothesis one, language retention was a more important predictor than the actual use of a Native language. While a significant difference existed between age and desired access to traditional medicines and a healer at a clinic and whether a healer would actually be consulted, this was contrary to the hypothesis which assumed that older, and hence more "traditional," respondents would be more likely to desire this access. In conclusion, some support was found for this hypothesis as there does

appear to be a relationship between language and desired access to traditional medicines and a healer, as well as proposed consultations with a healer at a clinic; thus hypothesis four is accepted.

CHAPTER SIX: DISCUSSION

6.1 Summary of Results

The data presented here suggests that traditional health care systems continue to play an important role in the health care of urban Native respondents. One-third of those interviewed had seen a healer at some time, and almost one-half (48.5%) of the sample had used traditional herbs and/or sweetgrass in the past year. While few people had participated in a sweat in the past year this likely relates to the fact that sweats largely occur in rural areas and on reserves, and financial constraints can make travel difficult.

Use of traditional health care systems was not found to be related to Indian status; rather, utilization was generalized among status Indian, non-status Indian respondents, with Metis respondents showing less utilization than the other two groups. Utilization of traditional health care systems was found to be related to the ability to speak a Native language. This parallels the findings of Fuchs and Bashshur's study of the use of traditional medicine among Native Americans in the San Francisco Bay area which also discovered that Native Americans who speak their Native language were significantly more likely to

use traditional medicine.[410] A relationship was also found to exist between both education and income level and utilization, with those utilizing traditional health care systems having a significantly higher education and income level. This contrasts with Fuchs and Bashshur's findings which pointed to no relationship between education or income level and use of traditional medicine.[411] Use of traditional health care systems was not found to be related to difficulties receiving health care in the Western health care system. Again this contrasts with Fuchs and Bashshur's study which discovered that respondents who experienced difficulty receiving Anglo medical care tended to resort to use of traditional medicine. Use of traditional health care systems was not found to detract from use of the Western health care system, which parallels Fuchs and Bashshur's findings.[412]

It is clear that many of the respondents in this study want access to traditional medicines and a healer within the city (58.9%), while even more stated that they would actually consult with a healer if one were available at the Westside Clinic or a similar facility (64.4%). Again, the ability to speak a Native language was found to be significantly related to whether respondents wanted traditional medicines and a healer available, and also whether respondents would consult with a healer at Westside Clinic. The number of years

respondents had lived in the city was also found to be related to desired access to traditional medicines and a healer, with those desiring access living in the city significantly fewer years than those not desiring this access. It appears that traditional healers are not widely available in the city as only 6.0% of the sample knew of a healer in Saskatoon.

It would appear from this study that traditional medicine and related beliefs are still an important part of Native culture. Further, many respondents (33.3%) stated that they wanted to have a chance to learn about traditional medicine. This is supported by the fact that those who wanted traditional medicines or a healer available in the city and stated that they would consult with a healer were significantly younger than those who did not desire the availability of traditional medicines/healer or would not consult with a healer. It seems that young Native people have a strong desire to learn about traditional medicine because it is a part of their heritage. But is it at all feasible to propose that traditional health care systems be brought more formally into the urban centre? Some of the issues and concerns related to such a proposal, prefaced by a discussion of the state of Western medicine and the relevance of traditional medicine today, will now be discussed.

6.2 The Western Health Care System and the Role of Traditional Medicine Today

Much has been written about the insensitivity of physicians and their inability to relate to their patients as fellow human beings. While some in the medical establishment have accused medical anthropologists and medical sociologists of "doctor-bashing," in fact some important issues have been brought to the forefront. As Dossey has argued, Western medicine, while making great technological strides, appears to have degenerated to a remote and dehumanzing experience for the patient.[413] This attitude seems to be widely held by lay-people: one only need speak to someone who has recently been in a teaching hospital to hear stories of how they were subjected to poking and proding by medical students on rounds, followed by the inevitable discussion of "the case" with complete disregard for the presence of the patient. The patient can become completely dissociated from his/her body; "the body" can be put through a series of sometimes painful tests, often with no regard for the fears of the patient. At times the tests are not adequately explained beforehand, and it does not help the matter that each type of specialized test is performed by another technician. Often the technicians are physically isolated from the patient as they operate the machines from a separate room, and the

patient is left to endure the testing alone. Thus the patient is not able to develop a rapport with the people involved in his/her health care, but rather "the body" is shifted from site to site within the hospital for testing. Clearly, this can be a dehumanizing and frightening experience for the patient who is likely already disquieted because of his/her illness.

This sense of alientation from one's health care providers is not limited to teaching hospitals, however, but exists in non-teaching hospitals, and even in small clinics and physician's offices. Virtually everyone has had the experience of visiting a physician for an illness only to have the physician elicit one's symptoms in the most expedient manner possible, scribble down a prescription, and then make it clear that the visit has concluded. Many physicians appear to have no interest in knowing about <u>you</u> and your thoughts on what might be contributing to or causing your illness (i.e. your explanatory model of the illness); rather, their concern is "the body" and correcting the body's problem or controlling the body's symptoms.

Mehl argues that modern biomedicine "arose in virtual contempt" of traditional medicines, and that religion and medicine began to separate during the Renaissance.[414] The prevailing paradigm of medicine came to be that of the body as a mechanical device, encapsulated in the 17th century Cartesian philosophy

of Descartes which asserted the distinction between mind and body known as Cartesian dualism.[415] The reductionism of biomedicine has continued to the present, with researchers such as Good and Good arguing that this reductionism has led to the "impoverishment of the caring function of medicine."[416]

If the "caring function" of the Western health care system has been lost, what are the implications of this for the Native patient where a different culture and, occasionally, a different language from that of the health care providers can be factors complicating the health care encounter? Hanson has argued that while many Canadian urban Native people may have "superficially adopted the Canadian urban lifestyle," misunderstandings and communication problems between Native patients and non-Native health care providers are still very common.[417] From her experiences working at both a street-level social service liaison unit and in a community-based health centre in the inner city of Edmonton, Hanson cites three areas in which problems occur in the delivery of health care services to Natives in the inner city: firstly, the attitudes and values of the professional health care providers; secondly, the communication process between the health care providers and Native patients; and thirdly, the problem-solving methods employed by the health care providers. She notes how physicians are trained to

observe, assess and act in as efficient a manner as possible.[418] It can be extremely difficult for the Native patient to relate a concise list of symptoms to a physician both because the physician is likely a stranger and because of the underlying belief in Native culture that illness is multi-faceted, with many components and causes. Thus prescriptions may not be filled or if they are the pills may not be taken. Also, to the consternation of health care providers, appointments for x-rays or other tests or appointments with medical specialists may not be kept. This can seem irresponsible to health care providers, but may be perfectly logical to the Native patient who knows his/her illness cannot be "cured" simply through medication or tests.

In contrast to Western physicians, notes Hanson, the traditional Native healer approaches the initial encounter with the patient in a much different manner. The encounter is unhurried with a good deal of eye contact; even more important, there is a "shared understanding" between the healer and patient that the patient's illness may stem from any number of things in the patient's life. There is also a shared understanding of the role spirituality plays in health and illness. Rituals involved in the treatment of the patient bring the patient and healer closer together and also encircle the patient in his/her culture. There

is a real sense of personal caring in the health care encounter between the healer and patient, which clearly is often lacking in the health care encounter between physician and patient (Native or non-Native).[419]

One of the most important roles traditional health care systems could potentially come to play is in the alleviation of alcohol and drug abuse. As was throughly discussed in section 3.2.1., alcohol and drug abuse is a very serious problem among some Native populations and often leads to accidental and violent deaths. It is naive to assume that encouraging people to participate in the traditional elements of their culture, such as traditional health care systems, is going to result in an immediate solution for such a serious problem which is clearly tied to the socio-economic status of Native peoples and their marginalization within Western society. However, what traditional health care systems can do is to provide help for some individuals suffering through alcohol and drug abuse. Traditional Native teachings stress that one must have respect for one's body and that a harmony must be achieved between the mind, body and spirit which, of course, is antithetical to the physical abuse of one's body with alcohol or drugs (obviously this does not include traditional "drugs" such as peyote). Further, traditional teachings stress the importance of a spiritual life within oneself which provides one with

inner strength. When an individual is a member of a group which is marginalized within society anything that provides a positive source of strength (whether it is termed "psychological" or "spiritual") is of great importance in terms of one's survival.

As has been discussed in the literature review, the peyote ritual has gained success in the United States in the treatment of alcoholism among Native groups. Also, the traditional Spirit Dance of the Salish has been documented by Jilek to be very beneficial in the treatment of alcoholism among these people. Elements of traditional medicine and ceremonials do seem to have a very important role to play in the treatment of alcohol and drug abuse among Native peoples. However, such traditional treatment modalities can only treat the symptoms causing alcohol and drug abuse. To get at the true cause of these problems one must acknowledge the lack of an economic base for Native peoples today and, in fact, how this same scenario of alcoholism and drug abuse and concomitant accidental and violent deaths exists among aboriginal populations around the world who have also been marginalized and have had their traditional economies destroyed. It is believed, however, that while one must recognize the structural constraints which keep Native people in a marginalized position one must also be realistic in recognizing that these constraints are not going to disappear overnight,

if ever. Thus it is believed that something must be done now, if even on a small scale, to try to prevent the waste of so many human lives.

6.3 Traditional Health Care Systems in the Urban Centre

It is clear, both from the present research and other research, that Native patients still desire treatment from traditional healers.[420] Formalization of traditional medicine through the Western health care system is problematic, however. Firstly, there could be extreme reluctance on the part of Western health care providers, particularly physicians, to accept healers within the Western health care system because healers are not "scientifically" trained in medicine. Obviously, there could be conflicting treatment modalities if a patient is seeing both a traditional healer and a physician (for example, see the case of the diabetic patient in Chapter Five). Occasionally a healer will inform his/her patient that "Indian" and "white" medicines cannot be combined and thus the patient is advised to discontinue any medications prescribed by a physician.[421] Indeed, in interviews with healers, Gregory discovered that the majority felt strongly that Indian and white medicines could not be combined.[422]

The issue of the legal implications of traditional healing practices has to be considered, as well. Could a traditional healer who advises a patient to discontinue prescribed medication and/or prescribes a herbal medicine be sued for malpractice if the patient subsequently becomes ill or dies? Robb has noted that there are many unresolved legal issues in the area of traditional medicine. For example, could traditional healers be subject to criminal liability and would healers be able to obtain liability insurance?[423] Obviously the legalities of traditional healing practices would have to be examined in detail.

It must also be kept in mind that while there is reluctance on the part of Western physicians in regard to collaboration between the Western and traditional health care systems, there is also reluctance on the part of many healers who feel that traditional medicine must be protected and must remain separate from Western medicine. Again, this is a very important issue which would have to be examined further.

While a growing body of research is demonstrating the efficacy of some traditional treatments for particular illnesses and conditions which Western treatment modalities are unsuccessful in treating,[424] (also see Chapter Five for a discussion of "bad medicine,") attempts to "scientifically" document the efficacy of these treatment can face methodological

problems.[425] Until the western medical establishment can be given unequivocal proof of the efficacy of traditional treatments it likely will continue to be skeptical of traditional healers.

Another problem inherent in attempting to develop a formal relationship between the Western and traditional health care systems is that the traditional healer is being placed in an alien environment. Rappaport and Rappaport have suggested that this can lead to the "demystification" of the healer because the symbolic "props" which play an important role in the healer's image may have been neutralized. If the expected image is not conveyed, the patient may not feel secure in the health care encounter in terms of the ability of the healer to cure him/her.[426] Moerman has stressed the importance of "healing metaphors" in any medical treatment,[427] but practical problems can arise when the healer attempts to utilize his/her "healing metaphors" in the urban centre. O'Neil has noted how many Native healing ceremonies and rituals can interfere with the routine of a hospital, and also how the sweetgrass ceremony can be impossible in a hospital room because the burning sweetgrass sets off smoke detectors.[428] Morse et al. have also discussed the problems in accommodating a healer in a health care setting because of the traditional menstrual taboo which can require that menstruating women be absent from the building in

which the healer is practicing.[429] Healers themselves can feel uncomfortable in the alien environment of a health care setting which may render their medicine less effective.[430]

Because of the obstacles involved in bringing the traditional healer directly into the hospital, O'Neil argues that traditional health care systems cannot be integrated into the Western system at this point in time. Rather, O'Neil suggests that Native medical interpreters should come to play a greater role in the health care of Native patients.[431] The interpreters would act as a vital link to Native society and would consult with local elders in the city and maintain links to traditional healers. The interpreters would bring the healers to the hospital at a pre-determined locale in which sweetgrass could be burned and where the healer's treatment would not interfere with hospital regulations.[432]

Unfortunately an examination of the experiences of Native medical interpreters in Winnipeg found that the interpreters were not readily accepted by the physicians. Conflict was found to occur when interpreters "over-stepped" their authority and began to advocate for the needs of the patients rather than acting only as language interpreters. Conflicts also arose between the interpreters and the physicians when the interpreters were not expedient enough in obtaining

responses from patients. Instead, an interpreter would often attempt to establish some rapport with a patient before asking a physician's questions, or an interpreter would delay asking a physician's questions while he/she attempted to find a culturally-appropriate manner in which to explain a medical concept.[433] Translating medical terminology into a Native language can be problematic; however, the Saskatchewan Indian Languages Institute has produced a preliminary list of medical terminology translated into Cree.[434] While Native medical interpreters could come to play a greater role in the health care of urban Natives they may continue to be viewed by physicians as playing a relatively unimportant role in the health care system.

Traditional healers likely could not be integrated into the hospital environment at this time. However, healers perhaps could be situated at an alternative health care setting such as a clinic located in an core urban area with a high Native clientele, such as the Westside Community Clinic. At a clinic a healer could provide consultations for patients with treatment, if required, occuring in another location such as on a reserve.

Alternatively, a healer could practice out of an Indian organization, such as an Indian-Metis Friendship Centre. Both clinics in core urban areas and Friendship Centres could likely offer environments appropriate to

the practice of traditional medicine. This, of course, is predicated on the assumption that the staff of the facilities were committed to bringing traditional medicine to their clientele. This is necessary so that some of the difficulties already outlined, such as having menstruating women absent from the building if necessary or providing a room without a smoke detector or where a detector can be temporarily disconnected for the burning of sweetgrass, could be met. Further, the staffs' attitudes toward the healer are paramount. In the case of a clinic, conflict could arise between the physicians and a healer unless the physicians believed that the healer had an important role to play in the health care of the clinic's patients. This underscores the need for cross-cultural education in health care beliefs and practices in medical schools. It should be noted that the Medical Services Branch of Health and Welfare Canada has published a cross-cultural orientation manuel for Saskatchewan health care professionals which discusses traditional medicine and healers, cultural values and conflicts which can arise between Native patients and non-Native health care providers, as well as providing cultural backgrounds on the major Native groups in Saskatchewan.[435]

If a healer was located at a clinic with a predominately Native clientele, such as the Westside Clinic, physicians could refer patients to the healer

if they felt the patient had a culturally-determined illness, such as illness resulting from "bad medicine." Physicians could also refer patients to the healer in cases of what can broadly be referred to as spiritual problems (i.e. alcohol and/or drug abuse; depression) if they felt that the patients would benefit more from traditional treatments than Western modes of therapy. If a healer was located at a Friendship Centre, the centre could promote the healer through posters, pamphlets, and by word of mouth. Further, physicians from core urban clinics could refer patients to a healer at a Friendship Centre.

Organizations such as the Saskatoon Tribal Council play an important role in the health care of Native people coming to Saskatoon from northern areas by providing hotel accommodation and taxi services. They could expand this role by making these patients aware of the healer(s) in the city. It could be comforting for a Native patient unaccustomed to the urban centre to be able to visit a traditional healer, even if the purpose of the visit was solely for emotional support. Other organizations such as Native Alcohol Centres and local alcohol treatment facilities could refer Native clients to a healer for counselling in alcohol and drug abuse. As has been discussed in the literature review, it has been argued by some researchers that traditional Native psychotherapeutic treatment strategies are at

least as, if not more, effective than Western therapies in treating alcohol and drug abuse among Natives.

Probably the most difficult issue in proposing to bring traditional healers into the urban centre is determining exactly what role the healers should play in the health care of Native patients. In other words, should the healers treat organic illnesses or should their domain be strictly spiritual and emotional counselling (including treatment of supernaturally-caused illnesses). If healers are treating organic illnesses the difficulty arises in determing if they should treat <u>all</u> types of organic illnesses or treat only less serious organic illnesses.

Obviously, in arguing for healers in the urban centre it would be irresponsible to reject the role of Western medicine in the health care of Native patients. It would be more appropriate to accept that both the Western and traditional health care systems have their own area of expertise: physicians are likely superior in the treatment of many types of organic illnesses, while healers are likely superior in the treatment of supernaturally-caused illnesses and in some cases of spiritual and emotional counselling. Thus a healer would have to be willing to refer a patient to a physician for treatment when the patient's illness was out of the healer's domain of expertise; however, the healer could still play an important role in the

patient's health care by providing emotional support, particularly in cases of serious illness, by helping to "make sense" of the illness for the patient.

Healers could also play an important role in the treatment of some chronic conditions which Western medicine can do little for, such as arthritis and rheumatism. This is especially so because these conditions tend to afflict the elderly and elderly Natives could gain great emotional support from a traditional healer who represents a link to the patient's culture. Indeed this could be the healer's greatest role: namely, the link he/she represents to Native culture because the healer is the embodiment of Native culture.

It could be the case, however, that actual treatment by a healer might be best suited to a reserve. Perhaps patients could have contact with healers within the urban setting for emotional and spiritual counselling. Robb has suggested that pursuant to s. 81 of the Indian Act bands have the power to pass health by-laws. Thus, assuming these by-laws were not disallowed by the Minister of Indian Affairs, traditional Indian medicine clinics could be set up on reserves. Further, notes Robb, such by-laws would allow the clinic freedom in terms of not being bound by the Medical Profession Act; this act makes it an offense for anyone but a registered physician to practice

medicine, which obviously could prove problematic for a traditional healer.[436] Perhaps some type of "registry" of traditional healers would have to be 5developed to avoid the problem of charlatans. While a reserve could "validate" its own healer(s), an urban clinic may need to have some type of formal validation that a particular individual is recognized by at least one Indian community as a healer. If actual healing took place on reserves, urban clinics and physicians could play a role by referring Native patients to a healer if it was felt that a patient would benefit from treatment by a healer.

6.4 Recommendations

The following recommendations address not only the role traditional medicine has to play in the health care of Native patients, but also attempt to address Native health care and health needs in Saskatoon and across Canada.

1. A traditional healer(s) should be made available to provide counselling to Native patients and Native clientele of health-related organizations either at a health care facility, such as the Westside Clinic, or at an Indian organization, such as the Indian-Metis Friendship Centre. If only one healer could be made available he/she should be of Plains Cree background as

the majority of respondents in this study were Plains Cree. Clearly, future examination into the legalities of traditional medicine must take place. As has already been discussed, the issue of whether traditional healers could be sued and whether they should carry liability insurance must be resolved.

2. The Medical Services branch of Health and Welfare Canada must begin to accept responsibility for the health care of urban Natives. While Medical Services has traditionally limited its role to the health care of non-urban Natives, it must begin to expand this role to include urban Natives who can "fall between the cracks" in terms of the Western health care system because their health care is no longer a federal responsibility.

Traditionally, a healer receives only a ritual payment, such as tobacco and a square of cloth from his/her patients; thus, a healer would not be able to earn a living from the payments of patients. This is where Medical Services could play a vital role by providing some type of funding for an urban traditional healer and could also more actively promote the importance of traditional health care systems in its publications. Medical Services could also provide funds for the establishment and maintenance of a permanent sweat lodge either within the city (eg. on the riverbank, which would involve negotiations with the

Saskatoon Meewasin Valley Authority) or in a rural setting close to the city (eg. the Moose Woods reserve). The healer would then be able to utilize the sweat lodge in the treatment of his/her patients.

3. Links should be set up between the city's hospitals (University, City and St. Pauls), the Westside Community Clinic, the Saskatoon Tribal Council and the Indian-Metis Friendship Centre to promote Native health care. If a healer(s) were made available in the city, these organizations and facilities would have to work together to make the availability of traditional health care services known to Native patients.

4. The present research found that some communication problems exist between Native patients and Western health care providers. The majority of Native patients in the study (75.7%) spoke a Native language as well as English which could be a factor contributing to these communication problems. As was previously noted, a proposal for a Native medical interpreters program was made a number of years ago by the Saskatoon Joint Hospital Committee due to a recognition by the committee of the special health care needs of Native people in Saskatoon. Unfortunately this proposal was not acted upon. The present research again underscores the need for such a program.

Related to this is the need for cross-cultural education for medical students in terms of the traditional health care beliefs of Native patients. Healers could come to play an important role in the education of medical students and practicing physicians by providing seminars in which traditional health care belief and treatment modalities were discussed. Clearly, the only way in which physicians will come to respect traditional health care systems and realize all they have to offer is through first-hand knowledge of these systems. Increased cross-cultural training for nurses employed by Medical Services is also needed. Perhaps systematic study into the efficacy of traditional medical treatments, perhaps initially in terms of treatment of alcohol and drug abuse, is needed in order to demonstrate their utility to Western health care providers.

It is sincerely hoped that the present research will act as a vehicle for further research into the health status and health needs of urban Native populations. More research is needed into the health care utilization patterns of Native people in Saskatoon. While the present research has identified some socio-cultural and socio-economic barriers among the Native population, further research is needed to more fully examine the extent to which such barriers are interfering with utilization of the Western health

care system by the Native population. It could be the case that while the overall project examining the Native utilization patterns of the Western health care system at the Westside Community Clinic found a high level of utilization, this was precisely because of the nature of the clinic itself. The "non-threatening" and friendly atmosphere of the Westside clinic may be responsible for this high level of utilization and thus may make Saskatoon somewhat unique. Certainly, more research is needed in urban centres across Canada, and within Saskatchewan (such as in the cities of Prince Albert and Regina). Following the lead from this study, assessments should also be made of the utilization of traditional health care systems among urban Natives in other centres and whether these populations also desire access to these systems in the urban context.

The overall project examining utilization of the Western health care system found little difference between the utilization patterns of Natives and non-Natives. Obviously non-Natives using the Westside clinic were as economically disadvantaged as the Native clientele; thus, research is needed to examine the utilization patterns of middle and upper-class non-Natives and Natives in order to be able to make some determination as to whether the utilization of the Western health care system by poor urban Natives (i.e. the Westside sample) is optimum or even adequate.

It must again be stressed that there are inherent limitations in this study and the overall project because of the use of a non-random sampling technique. Thus the findings speak for a specific population in a specific geographic location within Saskatoon. The extent to which these findings can be generalized to Natives of a higher socio-economic status is not known, nor is it known the extent to which these findings represent other Canadian urban Native populations. Nevertheless, this study represents probably the first extensive examination of the role of traditional health care systems among urban Canadian Native populations, and the overall project examining utilization of the Western health care system by urban Natives is also unique. More such research is urgently needed; researchers have, to this point, largely ignored the health issues of urban Native populations and without concrete research findings little can be done in the way of benefiting these populations. It is gratifying that the Westside Community Clinic has recently been provided with funding to hire a Native health worker to act as a liason between the Native community and medical and social organizations as well as to develop programs for Native clientele at the clinic. This small step is certainly a step in the right direction. It is hoped that this study and future research can work for the real benefit of Native peoples, and if this study

has contributed in even the smallest way to this end then it has served its purpose.

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Appendix A: Interview Schedule

West Side Clinic Health Survey - 1987

1. I.D. NUMBER:_____ DATE: _____

PART 1: DEMOGRAPHIC AND SOCIOLOGICAL DATA

2. Sex:
   [ ] 1. male
   [ ] 2. female

3. How old are you ? _____ years

4. What is your marital status:

   [ ] 1. single
   [ ] 2. married (including common-law) and living with spouse
   [ ] 3. divorced, widowed, or separated

5. Do you have any children who are presently dependent upon you for support ?

   [ ] 1. Yes [GO TO Q.6]
   [ ] 2. No [GO TO Q.8]

6. How many dependent children do you have ?

   _____

7. What are their ages ?

8. Which of the following would best describe your ethnic or Native status? [READ LIST]

   [ ] 1. I am a status Indian (with or without treaty)
   [ ] 2. I am a non-status Indian
   [ ] 3. I am an Inuk (Eskimo)
   [ ] 4. I am a Metis
   [ ] 5. I am a Caucasian ("White")
   [ ] 6. I am an Oriental
   [ ] 7. None of these. I am _____

   [IF 1, GO TO Q.9]
   [IF 2 THRU 7, GO TO Q.10]

9. If you are a status Indian, have you recently become a status Indian as a result of the changes to the Indian Act ?

   [ ] 1. Yes
   [ ] 2. No

10. Which term would best describe your cultural background ?
[READ LIST]

[ ] 1. I am a northern Cree Indian
[ ] 2. I am a Plains Cree Indian
[ ] 3. I am a Chipeywan or Dene Indian
[ ] 4. I am a Dakota Indian
[ ] 5. I am a Saulteaux Indian
[ ] 6. I am a Blackfoot Indian
[ ] 7. I am a Metis
[ ] 8. I am of Western European descent
[ ] 9. I am of Eastern European descent
[ ] 10. I am of Asian descent
[ ] 11. None of these. I am a _____.

[IF 1 THRU 7, GO TO Q. 11]
[IF 8 THRU 10, GO TO Q.12]
[IF 11, GO TO EITHER 11 OR 12 AS APPROPRIATE]

11. Have you ever been married to a non-Native or lived with a non-Native in a marriage relationship ?

[ ] 1. Yes
[ ] 2. No

GO TO Q.13

12. Have you ever been married to a Native person or lived with a Native person in a marriage relationship ?

[ ] 1. Yes
[ ] 2. No

13. What was the first language you learned to speak ?

[ ] 1. Cree
[ ] 2. Chipeywan or Dene
[ ] 3. Saulteaux
[ ] 4. Dakota
[ ] 5. Blackfoot
[ ] 6. Michif
[ ] 7. English
[ ] 8. French
[ ] 9. Other _____

[IF RESPONDENT IS NATIVE GO TO Q.14]
[IF RESPONDENT IS NON-NATIVE GO TO Q.16]

14. Are you able to speak any Indian languages today ?

[ ] 1. Cree
[ ] 2. Chipewyan or Dene
[ ] 3. Saulteaux
[ ] 4. Dakota
[ ] 5. Blackfoot
[ ] 6. Michif
[ ] 7. Other _____
[ ] 8. None

[IF 1 THRU 7, GO TO Q.15]
[IF 8, GO TO Q. 16]

15. How often do you speak this language ? [READ LIST]

[ ] 1. most of the time
[ ] 2. about half the time
[ ] 3. only occasionally
[ ] 4. rarely or never

16. What is the highest grade you have completed at school ?

_____

17. What is you present employment situation ?

[ ] 1. employed full-time
[ ] 2. employed part-time
[ ] 3. unemployed

18. What would you estimate your income to be for the last year, before taxes ?

_____

19. Are you presently receiving social assistance or welfare?

[ ] 1. Yes
[ ] 2. No

20. Are you presently receiving unemployment insurance?

[ ] 1. Yes
[ ] 2. No

21. How many different places have you lived in Saskatoon in the last year ?

_____

22. In which area of the city are your currently living ?
[USE MAP]

West Side:

[ ] 1. Caswell Hill
[ ] 2. City Park
[ ] 3. Confederation Park
[ ] 4. Downtown
[ ] 5. Dundonald
[ ] 6. Fairhaven
[ ] 7. Parkridge
[ ] 8. Holiday Park
[ ] 9. Hudson Bay Park
[ ] 10. Larkhaven
[ ] 11. Lawson Heights
[ ] 12. Massey Place
[ ] 13. Mayfair
[ ] 14. McNab Park
[ ] 15. Meadow Green
[ ] 16. Montgomery Place
[ ] 17. Mount Royal
[ ] 18. Mount Royal West
[ ] 19. North Park
[ ] 20. Pacific Heights
[ ] 21. Pleasant Hill
[ ] 22. Pleasant Hill West
[ ] 23. Richmond Heights
[ ] 24. River Heights
[ ] 25. Riversdale
[ ] 26. Silverwood Heights
[ ] 27. Westmount
[ ] 28. Westview
[ ] 29. Woodlawn

[ ] 30. East Side: [name of neighbourhood or address]

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23. Which of the following situations best describes your present living arrangements ? [READ LIST]

[ ] 1. I rent an apartment
[ ] 2. I rent a house
[ ] 3. I own (or am buying) a house
[ ] 4. I live with some friends or members of my family
[ ] 5. I do not have a place to live at this time
[ ] 6. Other _____

24. How many years in total have you lived in Saskatoon ? _____

25. What do you feel is your home community ?

[ ] 1. Saskatoon
[ ] 2. Other (name) _____

[IF 1, GO TO Q.27]
[IF 2, GO TO Q.26]

26. How often do you return to this community ? [READ LIST]

[ ] 1. once a year or less
[ ] 2. two or three times a year
[ ] 3. four or more times a year

PART 2: HEALTH CARE PATTERNS

27. If you wanted medical treatment in Saskatoon for something that you felt was not an emergency, where would you probably go first ?

[ ] 1. West Side Clinic
[ ] 2. St. Paul's Hospital
[ ] 3. Medi-Clinic or drop-in medical clinic
[ ] 4. Private physicians office
[ ] 5. Other (name): _____

28. If you wanted medical treatment in Saskatoon for something that you felt was an emergency, where would you probably go first?

[ ] 1. West Side Clinic
[ ] 2. St Paul's Hospital
[ ] 3. Medi-clinic or drop-in medical clinic
[ ] 4. Private physicians office
[ ] 5. City Hospital
[ ] 6. University Hospital
[ ] 7. Other (name): _____

29. Do you have a regular or family doctor ?

[ ] 1. Yes [GO TO Q.30]
[ ] 2. No [GO To Q.32]

30. What is his or her name ?

[ ] 1. Name _____
[ ] 2. Can't remember or don't know

31. When was the last time you went to see this doctor ?

[ ] 1. Within the last month
[ ] 2. Within the last three months
[ ] 3. Within the last year
[ ] 4. More than a year ago

[GO TO Q.33]

32. Why don't you have a regular or family doctor ?

_____
_____
_____
_____

33. Do you feel it is important to have a regular or family doctor ?

[ ] 1. Yes
[ ] 2. No

34. When was the last time you had a complete physical examination by a doctor ?

[ ] 1. Within the last year
[ ] 2. Within the last three years
[ ] 3. More than three years ago
[ ] 4. Can't remember
[ ] 5. I have never had a physical examination

35. Have you been admitted to a hospital in the last year ?

[ ] 1. Yes [GO TO Q.36]
[ ] 2. No [GO TO Q.41]

36. How many times ? [If more than once, use Supplementary Form A]

_____

37. Why were you hospitalized ?

_____
_____
_____
_____
_____

38. To which hospital were you admitted ?

[ ] 1. University
[ ] 2. St. Paul's
[ ] 3. City
[ ] 4. Other _____

39. Did you pick the hospital to go to, or were you sent there by a doctor or taken there by an ambulance ?

[ ] 1. Picked [GO TO Q.40]
[ ] 2. Referred or taken [GO TO Q.41]

40. Why did you pick this particular hospital to go to ?

_____
_____
_____
_____
_____

41. In the last year, have you voluntarily gone to an emergency room at a Saskatoon hospital for medical care ?

[ ] 1. Yes [GO TO Q.42]
[ ] 2. No [GO TO Q.49]

42. How many times ? [If more than once, use Supplementary Form B] _____

43. Which hospital did you go to ?

[ ] 1. University
[ ] 2. St. Paul's
[ ] 3. City

44. Why did you go to this particular hospital ?

---

45. What time of the day was it when you went to this emergency room ?

[ ] 1. Daytime (6:00 a.m. to 6:00 p.m.)
[ ] 2. Evening (6:01 p.m. to midnight)
[ ] 3. Nightime (12:01 a.m to 5:59 a.m.)

46. What was the particular medical problem which brought you to the emergency room ?

---

47. At the time did you feel that your medical problem required the immediate attention of a doctor?

[ ] 1. Yes
[ ] 2. No

48. Were you admitted to the hospital, or treated and released ?

[ ] 1. Admitted
[ ] 2. Treated and released

49. Have you gone to a Medi-Clinic or drop-in medical clinic (not including this clinic) in the last year ?

[ ] 1. Yes [GO TO Q.50]
[ ] 2. No [GO TO Q.51]

50. How many times have you gone to a Medi-Clinic or drop-in clinic in the last year?

_____

51. When was the last time you went to see a dentist ?

[ ] 1. In the last year
[ ] 2. Two or more years ago
[ ] 3. Can't remember
[ ] 4. I have never been to see a dentist

52. Do you have a regular dentist that you see ?

[ ] 1. Yes [GO TO Q.53]
[ ] 2. No [GO TO Q.54]

53. What is his or her name ?

[ ] 1. Name _____
[ ] 2. Can't remember or don't know

54. When was the last time you had an eye examination ?

[ ] 1. Within the last two years
[ ] 2. More than two years ago
[ ] 3. Can't remember
[ ] 4. I have never had an eye examination.

55. Have you ever been turned away from medical care by a clinic, doctor's office, or hospital ?

[ ] 1. Yes [GO TO Q.56]
[ ] 2. No [GO TO Q.58]

56. Where were you turned away ?

---

57. Why were you turned away ?

Have you ever had any of the following problems in obtaining health care in Saskatoon ?

58. Explaining my health problem to the doctor or nurse

[ ] 1. Yes
[ ] 2. No

59. Understanding the language used by a doctor or nurse

[ ] 1. Yes
[ ] 2. No

60. Finding a doctor or nurse

[ ] 1. Yes
[ ] 2. No

61. Travelling to see a doctor or nurse

[ ] 1. Yes
[ ] 2. No

62. Making an appointment with a doctor or nurse

[ ] 1. Yes
[ ] 2. No

63. Finding a baby sitter so that I may see a doctor or nurse

[ ] 1. Yes
[ ] 2. No

Here is a bottle of medicine that anyone can purchase in a drug store.

64. Can you tell me what kind of medicine it is ? [Decongestant]

[ ] 1. Yes
[ ] 2. No

65. Can you tell me what this medicine is used for ?

[to stop a runny nose; to alleviate nasal congestion; ask them to be more specific than saying "a cold"]

[ ] 1. Yes
[ ] 2. Cold
[ ] 3. No

66. If you wanted to use this medicine, how much would you take ? [adults: 1 or 2 teaspoons]

[ ] 1. Correct dose
[ ] 2. Incorrect dose
[ ] 3. Don't know

67. How often would you take this medicine ?
[3 or 4 times daily]

[ ] 1. Correct
[ ] 2. Incorrect
[ ] 3. Don't know

Have you ever had any of the following money problems ?

68. Paying for a baby-sitter so that I may go to a doctor, or take one of my children to the doctor.

[ ] 1. Yes
[ ] 2. No

69. Paying for prescription drugs.

[ ] 1. Yes
[ ] 2. No

70. Paying for non-prescription drugs and other medicines.

[ ] 1. Yes
[ ] 2. No

71. Has any health care professional, such as a doctor or nurse, ever treated you in a way that made you feel bad ?

[ ] 1. Yes
[ ] 2. No

72. Can you describe the incident ? [where;when; what was said or done]

---

73. Why do you think they treated you this way ?

---

74. Have you ever had problems understanding a doctor's instructions to you concerning a health problem ?

[ ] 1. Yes
[ ] 2. No

75. Have you ever had problems understanding the doctor's directions for taking prescribed medication ?

[ ] 1. Yes
[ ] 2. No

76. Do you have a regular pharmacy or drug store that you use to obtain prescribed drugs ?

[ ] 1. Yes [GO TO Q.77]
[ ] 2. No [GO TO Q.78]

77. Which pharmacy is it, or where is it if you don't recall the name ?

[ ] 1. Name/Location _____
[ ] 2. Can't Remember

78. How did you travel to this clinic today ?

[ ] 1. Bus
[ ] 2. Personal automobile
[ ] 3. Some one gave me a ride
[ ] 4. Walked
[ ] 5. Some other method (explain) _____

79. Have you ever been to this clinic before ?

[ ] 1. Yes [GO TO Q.80]
[ ] 2. No [GO TO Q.81]

80. Would you say that the clinic is the place you usually go to for medical treatment ?

[ ] 1. Yes
[ ] 2. No

81. Did you come here today to see a doctor for yourself, or for someone else ?

[ ] 1. Self
[ ] 2. Someone else [who] _____

82. What is the health problem that brought you to this clinic today?

[ ] 1. For myself

_____
_____
_____

[ ] 2. For someone else

_____
_____
_____

83. Before you saw the doctor today, what did you think was the cause of this health problem ?

---

84. When did you first begin to notice this problem ?

---

85. Is this your first visit to a medical doctor or nurse for this problem ?

[ ] 1. Yes
[ ] 2. No

86. Have you done anything yourself to correct the problem ?

---

87. Did you have any trouble explaining your health problem to the doctor or nurse ?

[ ] 1. Yes [GO TO Q.88]
[ ] 2. No [GO TO Q.89]

88. What was the trouble ?

---

89. Why did you decide to come here and not to any other health facility ?

[ ] 1. To see a particular doctor
[ ] 2. Atmosphere (the people are friendly; like the place)
[ ] 3. The clinic is close
[ ] 4. Other health facilities are not open
[ ] 5. Other _____

90. In the future, do you think that you will return to this clinic for your health needs ?

[ ] 1. Yes [GO TO Q.91]
[ ] 2. No [GO TO Q.92]

91. Why will you return here?

[ ] 1. To see a particular doctor
[ ] 2. Atmosphere (the people are friendly; like the place)
[ ] 3. The clinic is close
[ ] 4. Other _____

GO TO Q.93

92. Why won't you return here ?

---

93. Is there anything the clinic might do to improve its services to patients ?

---

94. How did you first learn about the clinic ?

[ ] 1. Happened to see it one day
[ ] 2. Was told about it by a friend or member of my family
[ ] 3. Was told about it by someone else
[ ] 4. Was referred to it by another health professional
[ ] 5. Other (explain) _____

PART 3: TRADITIONAL MEDICINE (NATIVE RESPONDENTS ONLY)

Some Native people believe strongly in Indian medicine, and will visit an Indian doctor or medicine man for certain health problems. Other Native people either do not believe in Indian medicine or choose, for other reasons, not to consult with Indian doctors. It is important that we learn the extent to which Native patients are consulting with Indian doctors, because we feel that Indian medicine is important. We have a few questions we would like to ask you about this, and would hope that you would answer them as honestly as you have all our other questions. We will not ask you to reveal any of the secrets of Indian medicine.

95. Would you like to see some of the Indian medicine ways available in this clinic?

[ ] 1. Yes
[ ] 2. No

96. Why or why not ?

---

97. If an Indian doctor or medicine man were available in this clinic, do you think you would come to see him or her ?

[ ] 1. Yes
[ ] 2. No

98. For what kinds of problems would you come to see him or her?

---

99. Have you been to see an Indian doctor about the health problem that brought you here today ?

[ ] 1. Yes [GO TO Q.100]
[ ] 2. No [Go TO Q.103]

100. What did this Indian doctor say was your problem ?

---

101. What did this Indian doctor do to treat you ?

---

102. Do you think this treatment worked ?

[ ] 1. Yes
[ ] 2. No

[GO TO Q.105]

103. Are you planning on seeing an Indian doctor about the health problem that brought you here today ?

[ ] 1. Yes
[ ] 2. No

104. In the last year, have you gone to see an Indian doctor ?

[ ] 1. Yes [GO TO Q.105]
[ ] 2. No [GO TO Q.110]

105. Thinking of the last time you went to an Indian doctor, where did you go to see him or her?

[ ] 1. Saskatoon
[ ] 2. Other community or reserve (name) _____

106. In this case, why did you decide to go to an Indian doctor and not a white doctor ?

---

107. What did this Indian doctor say was your problem ?

---

108. What did this Indian doctor do to treat you ?

---

109. Do you think this treatment worked ?

[ ] 1. Yes
[ ] 2. No

[GO TO Q.112]

110. Have you ever gone to see an Indian doctor for a health problem ?

[ ] 1. Yes [GO TO Q.112]
[ ] 2. No [GO TO Q.111]

111. If not, why not ?

[ ] 1. You don't believe in Indian medicine
[ ] 2. Indian medicine frightens you
[ ] 3. You don't know how to find an Indian doctor
[ ] 4. There are no Indian doctors in Saskatoon
[ ] 5. You don't know enough about Indian medicine
[ ] 6. Some other reason _____

112. Do you think there are certain kinds of problems that Indian doctors can handle better than white doctors ?

[ ] 1. Yes [GO TO Q.113]
[ ] 2. No [GO TO Q.114]

113. Which kinds of problems?

---

114. Do you think there are certain kinds of problems that white doctors can handle better that Indian doctors ?

[ ] 1. Yes [GO TO Q.115]
[ ] 2. No [GO TO Q.116]

115. Which kinds of problems ?

---

116. In the last year, have you participated in a sweat ?

[ ] 1. Yes [GO TO Q.117]
[ ] 2. No [GO TO Q.118]

117. Where did you go to have this sweat ?

[ ] 1. Saskatoon
[ ] 2. Other community or reserve (name) _____

118. In the last year, have you been treated with, or treated yourself with any Indian medicines or herbs ?

[ ] 1. Yes
[ ] 2. No

119. Have you ever gone to see only an Indian doctor for a health problem ?

[ ] 1. Yes
[ ] 2. No

120. What was the health problem ?

---

121. Have you ever gone to see both a White doctor or nurse and an Indian doctor for the same health problem ?

[ ] 1. Yes [GO TO SUPPLEMENTARY FORM C]
[ ] 2. No [GO TO Q.122]

122. Do you know an Indian doctor in Saskatoon whom you would consider seeing for a health problem ?

[ ] 1. Yes [END INTERVIEW]
[ ] 2. No [GO TO Q.123]

123. Do you think you could find an Indian doctor in the city if you wanted one ?

[ ] 1. Yes
[ ] 2. No

Appendix B: Supplemental Form "A" (Hospital Visits)

SUPPLEMENTARY FORM A

Second Hospitalization ID _____

124. Why were you hospitalized ?

---

125. To which hospital were you admitted ?

[ ] 1. University
[ ] 2. St. Paul's
[ ] 3. City
[ ] 4. Other _____

126. Did you pick the hospital to go to, or were you sent there by a doctor or taken there by an ambulance ?

[ ] 1. Picked [GO TO Q.127]
[ ] 2. Referred or taken

127. Why did you pick this particular hospital to go to ?

[RETURN TO Q.41, OR CONTINUE IF NECESSARY]

Third Hospitalization

128. Why were you hospitalized ?

---

129. To which hospital were you admitted ?

[ ] 1. University
[ ] 2. St. Paul's
[ ] 3. City
[ ] 4. Other _____

130. Did you pick the hospital to go to, or were you sent there by a doctor or taken there by an ambulance ?

[ ] 1. Picked [GO TO Q.131]
[ ] 2. Referred or taken

131. Why did you pick this particular hospital to go to ?

[GO TO Q.41]

Appendix C: Supplemental Form "B" (Emergency Room Visits)

SUPPLEMENTARY FORM B

SECOND EMERGENCY ROOM VISIT ID _____

132. Which hospital did you go to ?

[ ] 1. University
[ ] 2. St. Paul's
[ ] 3. City

133. Why did you go to this particular hospital ?

---

134. What time of the day was it when you went to this emergency room ?

[ ] 1. Daytime (6:00 a.m. to 6:00 p.m.)
[ ] 2. Evening (6:01 p.m. to midnight)
[ ] 3. Nightime (12:01 a.m to 5:59 a.m.)

135. What was the particular medical problem which brought you to the emergency room ?

---

136. At the time did you feel that your medical problem required the immediate attention of a doctor ?

[ ] 1. Yes
[ ] 2. No

137. Were you admitted to the hospital, or treated and released ?

[ ] 1. Admitted
[ ] 2. Treated and released

[RETURN TO Q.49, OR CONTINUE IF NECESSARY]

THIRD EMERGENCY ROOM VISIT

138. Which hospital did you go to ?

[ ] 1. University
[ ] 2. St. Paul's
[ ] 3. City

139. Why did you go to this particular hospital ?

---

140. What time of the day was it when you went to this emergency room ?

[ ] 1. Daytime (6:00 a.m. to 6:00 p.m.)
[ ] 2. Evening (6:01 p.m. to midnight)
[ ] 3. Nightime (12:01 a.m. to 5:59 a.m.)

141. What was the particular medical problem which brought you to the emergency room ?

---

142. At the time did you feel that your medical problem required the immediate attention of a doctor?

[ ] 1. Yes
[ ] 2. No

143. Were you admitted to the hospital, or treated and released ?

[ ] 1. Admitted
[ ] 2. Treated and released

[GO TO Q.49]

Appendix D: Supplemental Form "C" (Utilization of Traditional and Western Health Care Systems for Same Illness Episode)

SUPPLEMENTARY FORM C ID _____

144. At that time what did you feel was your health problem ?

First Encounter

145. Which doctor or nurse did you see first ?

[ ] 1. White Doctor
[ ] 2. White Nurse
[ ] 3. Indian Doctor

146. Approximately when did you see him or her ?

---

147. What did they say was your health problem ?

---

148. What treatment did they suggest to restore your health ?

---

149. Did you follow their instructions ?

[ ] 1. Yes
[ ] 2. No

150. Did you get better as a result of seeing this person ?

[ ] 1. Yes
[ ] 2. No

[RETURN TO Q.122, OR CONTINUE IF NECESSARY]

Second Encounter

151. Who did you then go see ?

[ ] 1. White Doctor
[ ] 2. White Nurse
[ ] 3. Indian Doctor

152. Approximately when did you see him or her ?

---

153. At that time what did you feel was your health problem ?

---

154. What did they say was your health problem ?

---

155. What treatment did they suggest to restore your health ?

---

156. Did you follow their instructions ?

[ ] 1. Yes
[ ] 2. No

157. Did you get better as a result of seeing this doctor ?

[ ] 1. Yes
[ ] 2. No

[RETURN TO Q.122, OR CONTINUE IF NECESSARY]

Third Encounter

158. After seeing this person, did you then go to see another one ? Who was this ?

[ ] 1. Same White Doctor
[ ] 2. Different White Doctor
[ ] 3. Same White Nurse
[ ] 4. Different White Nurse
[ ] 5. Same Indian Doctor
[ ] 6. Different Indian Doctor

159. Approximately when did you see him or her ?

---

160. At that time what did you feel was your health problem ?

---

161. What did they say was your health problem ?

---

162. What treatment did they suggest to restore your health ?

---

163. Did you follow their instructions ?

[ ] 1. Yes
[ ] 2. No

164. Did you get better as a result of seeing this doctor ?

[ ] 1. Yes
[ ] 2. No

[RETURN TO Q.122, OR CONTINUE IF NECESSARY]

Fourth Encounter

165. After seeing this person, did you then go to see another one ? Who was this ?

[ ] 1. Same White Doctor (Episode ___)
[ ] 2. Different White Doctor
[ ] 3. Same White Nurse (Episode ___)
[ ] 4. Different White Nurse
[ ] 5. Same Indian Doctor (Episode ___)
[ ] 6. Different Indian Doctor

166. Approximately when did you see him or her ?

---

167. At that time what did you feel was your health problem ?

---

168. What did they say was your health problem ?

---

169. What treatment did they suggest to restore your health ?

---

170. Did you follow their instructions ?

[ ] 1. Yes
[ ] 2. No

171. Did you get better as a result of seeing this doctor ?

[ ] 1. Yes
[ ] 2. No

[RETURN TO Q. 122, OR CONTINUE IF NECESSARY]

Fifth Encounter

172. After seeing this person, did you then go to see another one Who was this ?

[ ] 1. Same White Doctor (Episode ___)
[ ] 2. Different White Doctor
[ ] 3. Same White Nurse (Episode ___)
[ ] 4. Different White Nurse
[ ] 5. Same Indian Doctor (Episode ___)
[ ] 6. Different Indian Doctor

173. Approximately when did you see him or her ?

---

174. At that time what did you feel was your health problem?

---

175. What did they say was your health problem ?

---

176. What treatment did they suggest to restore your health ?

---

177. Did you follow their instructions ?

[ ] 1. Yes
[ ] 2. No

178. Did you get better as a result of seeing this doctor ?

[ ] 1. Yes
[ ] 2. No

RETURN TO Q.122

Appendix E: Consent Form for Respondents

May I have your permission to obtain information from your medical record regarding your visit to the clinic today?

Yes

Print Name

Sign Name

Date

Appendix F: Use of Traditional Health Care Systems By Selected Indicators of Use of Western Health Care System

Table 14: Use of Traditional Health Care Systems[1] By Selected Indicators of Use of Western Health Care System

	Have a Family Dr.		Have a Regular Dentist	
	Yes	No	Yes	No
Ever See Healer				
Yes	81.8% (27)**	18.2% (6)	55.9% (19)	44.1% (15)
No	77.6% (52)	22.4% (15)	28.8% (19)	71.2% (47)
	chi=0.05 df=1 sign.=0.82		chi=5.88 df=1 *sign.=0.01	

	Have a Family Dr.		Have a Regular Dentist	
	Yes	No	Yes	No
Use Herbs				
Yes	76.0% (38)	24.0% (12)	42.0% (21)	58.0% (29)
No	83.7% (41)	16.3% (8)	34.7% (17)	65.3% (32)
	chi=0.49 df=1 sign.=0.48		chi=0.29 df=1 sign.=0.58	

	Have a Family Dr.		Have a Regular Dentist	
	Yes	No	Yes	No
Only Healer				
Yes	83.3% (15)	16.7% (3)	47.4% (9)	52.6% (10)
No	79.5% (62)	20.5% (16)	35.1% (27)	64.9% (50)
	chi=0.00 df=1 sign.=0.96		chi=0.52 df=1 sign.=0.46	

	Have a Family Dr.		Have a Regular Dentist	
	Yes	No	Yes	No
Healer & Dr.				
Yes	70.6% (12)	29.4% (5)	58.8% (10)	41.2% (7)
No	82.3% (65)	17.7% (14)	32.9% (26)	67.1% (53)
	chi=0.58 df=1 sign.=0.44		chi=2.97 df=1 sign.=0.08	

	Last Visit to Dr.	
	Within past year	Over one year
Ever See Healer		
Yes	60.7% (17)	39.3% (11)
No	53.3% (24)	46.7% (21)
	chi=0.14 df=1 sign.=0.70	

	Last Visit to Dr.	
	Within past year	Over one year
Use Herbs		
Yes	52.9% (18)	47.1% (16)
No	56.4% (22)	43.6% (17)
	chi=0.00 df=1 sign.=0.95	

Only Healer	Last Visit to Dr.: Within past year	Last Visit to Dr.: Over one year
Yes	62.5% (10)	37.5% (6)
No	56.4% (31)	43.6% (24)

chi=0.02
df=1
sign.=0.88

Healer & Dr.	Last Visit to Dr.: Within past year	Last Visit to Dr.: Over one year
Yes	72.7% (8)	27.3% (3)
No	55.0% (33)	45.0% (27)

chi=0.58
df=1
sign.=0.44

* denotes statistical significance at p<.05 level for this and all subsequent tables in appendices.

** represents raw number of respondents for this and all subsequent tables in appendices.

1. Variables measuring use of traditional health care systems are defined as follows for this and all subsequent tables in appendices:

   Ever See Healer= Respondent has seen a traditional healer at some time in his/her life.

   Use Herbs= Respondent has used traditional herbs and/or medicines in the past year.

   Only Healer= Respondent has seen a traditional healer and not a physician for a particular health problem at some time in his/her life.

   Healer & Dr.= Respondent has seen both a traditional healer and a physician for the same health problem at some time in his/her life.

Appendix G: Use of Traditional Health Care Systems By Selected Socio-Cultural and Socio-Economic Variables

Table 18: Use of Traditional Health Care Systems By Selected Socio-Cultural and Socio-Economic Variables

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Mean Age				
	31.9	29.7	29.3	29.7
	(34)	(67)	(15)	(35)
	T=1.11		T=-0.11	
	df=86		df=48	
	prob.=0.27		prob.=0.91	
	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
First Language Spoken				
Native	37.9%	62.1%	49.2%	50.8%
	(22)	(36)	(29)	(30)
English	27.9%	72.1%	51.2%	48.8%
	(12)	(31)	(21)	(20)
	chi=0.71		chi=0.00	
	df=1		df=1	
	sign.=0.40		sign.=1.00	
	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Languages Spoken Today				
Native & English	39.7%	60.3%	52.1%	47.9%
	(29)	(44)	(38)	(35)
English only	17.9%	82.1%	44.4%	55.6%
	(5)	(23)	(12)	(15)
	chi=3.41		chi=0.20	
	df=1		df=1	
	sign.=0.06		sign.=0.65	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Annual Income	$8462 (34)	$6607 (64)	$7056 (48)	$7535 (48)
	T=2.09 df=96 *prob.=0.03		T=-0.55 df=94 prob.=0.58	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Education (grade level)	9.3 (34)	8.3 (67)	8.7 (50)	8.5 (50)
	T=1.90 df=49 prob.=0.06		T=-0.34 df=98 prob.=0.74	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Mean Age	32.3 (19)	30.4 (78)	32.6 (17)	30.4 (80)
	T=0.71 df=95 prob.=0.48		T=0.81 df=95 prob.=0.42	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
First Language Spoken				
Native	21.1% (12)	78.9% (45)	19.3% (11)	80.7% (46)
English	17.5% (7)	82.5% (33)	15.0% (6)	85.0% (34)
	chi=0.03 df=1 sign.=0.86		chi=0.07 df=1 sign.=0.78	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Languages Spoken Today				
Native & English	22.2% (16)	77.8% (56)	19.4% (14)	80.6% (58)
English only	12.0% (3)	88.0% (22)	12.0% (3)	88.0% (22)
	chi=0.66 df=1 sign.=0.41		chi=0.28 df=1 sign.=0.59	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Annual Income				
	$8266 (19)	$7015 (76)	$8717 (17)	$6949 (78)
	T=1.16 df=93 prob.=0.24		T=1.58 df=93 prob.=0.12	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Education (grade level)				
	9.7 (19)	8.3 (78)	8.8 (17)	8.5 (80)
	T=2.33 df=95 *prob.=0.02		T=0.59 df=95 prob.=0.56	

Appendix H: Use of Traditional Health Care Systems By Native and Indian Status

Table 19: Use of Traditional Health Care Systems By Native and Indian Status

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Indian Status				
Status Indian	33.8% (24)	66.2% (47)	57.1% (40)	42.9% (30)
Non-status Indian/Metis	33.3% (10)	66.7% (20)	33.3% (10)	66.7% (20)
	chi=0.00 df=1 sign.=1.00		chi=3.85 df=1 *sign.=0.04	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Native Status				
Status Indian	33.8% (24)	66.2% (47)	57.1% (40)	42.9% (30)
Non-status Indian	61.5% (8)	38.5% (5)	16.7% (2)	83.3% (10)
Metis	11.8% (2)	88.2% (15)	44.4% (8)	55.6% (10)
	chi=8.17 df=2 *sign.=0.01		chi=6.98 df=2 *sign.=0.03	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Indian Status				
Status Indian	17.6% (12)	82.4% (56)	20.6% (14)	79.4% (54)
Non-status Indian/Metis	24.1% (7)	75.9% (22)	10.3% (3)	89.7% (26)
	chi=0.20 d.f.=1 sign.=0.64		chi=0.85 d.f=1 sign.=0.36	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Native Status				
Status Indian	17.6% (12)	82.4% (56)	20.6% (14)	79.4% (54)
Non-status Indian	46.2% (6)	53.8% (7)	15.4% (2)	84.6% (11)
Metis	6.3% (1)	93.8% (15)	6.3% (1)	93.8% (15)
	chi=7.79 df=2 *sign.=0.02		chi=1.88 df=2 sign.=0.38	

Appendix I: Use of Traditional Health Care Systems By Difficulty Receiving Medical Care in the Western Health Care System

Table 20: Use of Traditional Health Care Systems By Difficulty Receiving Medical Care in the Western Health Care System

Ever Had Difficulty:[1]	Ever See Healer: Yes	Ever See Healer: No	Use Herbs: Yes	Use Herbs: No
Finding a Dr.				
Yes	27.8% (5)	72.2% (13)	47.1% (8)	52.9% (9)
No	34.9% (29)	65.1% (54)	50.6% (42)	49.4% (41)
	chi=0.09 df=1 sign.=0.75		chi=0.00 df=1 sign.=1.00	

Making a Dr's Appointment	Ever See Healer: Yes	Ever See Healer: No	Use Herbs: Yes	Use Herbs: No
Yes	27.3% (6)	72.7% (16)	52.4% (11)	47.6% (10)
No	34.6% (27)	65.4% (51)	50.0% (39)	50.0% (39)
	chi=0.15 df=1 sign.=0.69		chi=0.00 df=1 sign.=1.00	

Explaining Health Problem to a Dr.	Ever See Healer: Yes	Ever See Healer: No	Use Herbs: Yes	Use Herbs: No
Yes	26.9% (7)	73.1% (19)	57.7% (15)	42.3% (11)
No	36.0% (27)	64.0% (48)	47.3% (35)	52.7% (39)
	chi=0.36 df=1 sign.=0.54		chi=0.46 df=1 sign.=0.49	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Understanding a Dr's. Language				
Yes	27.7% (13)	72.3% (34)	50.0% (23)	50.0% (23)
No	39.6% (21)	60.4% (32)	49.1% (26)	50.9% (27)
	chi=1.10 df=1 sign.=0.29		chi=0.00 df=1 sign.=1.00	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Understanding a Dr.'s Instructions (re: health problem)				
Yes	37.0% (10)	63.0% (17)	66.7% (18)	33.3% (9)
No	32.4% (24)	67.6% (50)	43.8% (32)	56.2% (41)
	chi=0.03 df=1 sign.=0.84		chi=3.24 df=1 sign.=0.07	

	Ever See healer		Use Herbs	
	Yes	No	Yes	No
Understanding a Dr.'s Directions (re: medication)				
Yes	37.5% (6)	62.5% (10)	60.0% (9)	40.0% (6)
No	32.9% (28)	67.1% (57)	48.2% (41)	51.8% (44)
	chi=0.00 df=1 sign.=0.94		chi=0.31 df=1 sign.=0.57	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Travelling to a Dr.				
Yes	20.9% (9)	79.1% (34)	57.1% (24)	42.9% (18)
No	43.1% (25)	56.9% (33)	44.8% (26)	55.2% (32)
	chi=4.48 df=1 *sign.=0.03		chi=1.02 df=1 sign.=0.31	

	Ever See Healer		Use Herbs	
	Yes	No	Yes	No
Paying for Prescription Drugs				
Yes	42.9% (9)	57.1% (12)	47.6% (10)	52.4% (11)
No	31.3% (25)	68.8% (55)	50.6% (40)	49.45 (39)
	chi=0.55 df=1 sign.=0.45		chi=0.00 df=1 sign.=0.80	

	Ever See healer		Use Herbs	
	Yes	No	Yes	No
Paying for Non-Prescription Drugs				
Yes	36.8% (14)	63.2% (24)	52.6% (20)	47.4% (18)
No	31.7% (20)	68.3% (43)	48.4% (30)	51.6% (32)
	chi=0.09 df=1 sign.=0.75		chi=0.04 df=1 sign.=0.83	

Were You Ever:	Ever See Healer: Yes	Ever See Healer: No	Use Herbs: Yes	Use Herbs: No
Made to "Feel Bad" By a Health Care Provider				
Yes	36.4% (8)	63.6% (14)	52.4% (11)	47.6% (10)
No	30.1% (22)	69.9% (51)	50.0% (36)	50.0% (36)
	chi=0.08 df=1 sign.=0.77		chi=0.00 df=1 sign.=1.00	

Were You Ever:	Ever See Healer: Yes	Ever See Healer: No	Use Herbs: Yes	Use Herbs: No
Turned Away From Medical Care				
Yes	25.0% (2)	75.0% (6)	62.5% (5)	37.5% (3)
No	34.1% (31)	65.9% (60)	47.8% (43)	52.2% (47)
	chi=0.01 df=1 sign.=0.89		chi=0.18 df=1 sign.=0.66	

Ever Had Difficulty:[2]	Only Healer: Yes	Only Healer: No	Healer & Dr.: Yes	Healer & Dr.: No
Finding a Dr.				
Yes	16.7% (3)	83.3% (15)	5.6% (1)	94.4% (17)
No	20.3% (16)	79.7% (63)	20.3% (16)	79.7% (63)
	chi=0.00 df=1 sign.=0.98		chi=1.29 df=1 sign.=0.25	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Making a Dr.'s Appointment				
Yes	15.0% (3)	85.0% (17)	25.0% (5)	75.0% (15)
No	21.1% (16)	78.9% (60)	15.8% (12)	84.2% (64)
	chi=0.08 df=1 sign.=0.77		chi=0.39 df=1 sign.=0.52	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Explaining a Health Problem to a Dr.				
Yes	16.7% (4)	83.3% (20)	20.8% (5)	79.2% (19)
No	20.5% (15)	79.5% (58)	16.4% (12)	83.6% (61)
	chi=0.01 df=1 sign.=0.90		chi=0.03 df=1 sign.=0.85	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Understanding a Dr.'s Language				
Yes	22.2% (10)	77.8% (35)	11.1% (5)	88.9% (40)
No	17.3% (9)	82.7% (43)	23.1% (12)	76.9% (40)
	chi=0.12 df=1 sign.=0.72		chi=1.63 df=1 sign.=0.20	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Understanding a Dr.'s Instructions (re: health problem)				
Yes	34.6% (9)	65.4% (17)	15.4% (4)	84.6% (22)
No	14.1% (10)	85.9% (61)	18.3% (13)	81.7% (58)
	chi=3.87 df=1 *sign.=0.04		chi=0.00 df=1 sign.=0.97	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Understanding a Dr.'s Directions (re: medication)				
Yes	40.0% (6)	60.0% (9)	13.3% (2)	86.7% (13)
No	15.9% (13)	84.1% (69)	18.3% (15)	81.7% (67)
	chi=3.28 df=1 sign.=0.06		chi=0.00 df=1 sign.=0.92	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Travelling to a Dr.				
Yes	14.3% (6)	85.7% (36)	14.3% (6)	85.7% (36)
No	23.6% (13)	76.4% (42)	20.0% (11)	80.0% (44)
	chi=0.79 df=1 sign.=0.37		chi=0.21 df=1 sign.=0.64	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Paying for Prescription Drugs				
Yes	40.0% (8)	60.0% (12)	15.0% (3)	85.0% (17)
No	14.3% (11)	85.7% (66)	18.2% (14)	81.8% (63)
	chi=5.13 df=1 *sign.=0.02		chi=0.00 df=1 sign.=0.99	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Paying for Non-Prescription Drugs				
Yes	21.6% (8)	78.4% (29)	21.6% (8)	78.4% (29)
No	18.3% (11)	81.7% (49)	15.0% (9)	85.0% (51)
	chi=0.01 df=1 sign.=0.89		chi=0.31 df=1 sign.=0.57	

	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Were You Ever:				
Made to "Feel Bad" By a Health Care Provider				
Yes	20.0% (5)	80.0% (15)	25.0% (5)	75.0% (15)
No	16.9% (12)	83.1% (59)	14.1% (10)	85.9% (61)
	chi=0.00 df=1 sign.=1.00		chi=0.67 df=1 sign.=0.41	

Were You Ever:	Only Healer		Healer & Dr.	
	Yes	No	Yes	No
Turned Away From Medical Care				
Yes	28.6% (2)	71.4% (5)	14.3% (1)	85.7% (6)
No	18.0% (16)	82.0% (73)	16.9% (15)	83.1% (74)
	chi=0.03 df=1 sign.=0.85		chi=0.00 df=1 sign.=1.00	

1. Subsequent variables are also prefaced by "ever had difficulty" until otherwise indicated.

2. Subsequent variables are also prefaced by "ever had difficulty" until otherwise indicated.

Appendix J: Desired Access to Traditional Health Care Systems in the Urban Centre By Selected Socio-Cultural Variables

Table 21: Desired Access to Traditional Health Care Systems in the Urban Centre By Selected Socio-Cultural Variables

	Want Traditional Medicines/ Healer at Clinic		Would Visit a Healer at Clinic	
	Yes	No	Yes	No
Native Status				
Status Indian	62.5% (40)	37.5% (24)	67.2% (43)	32.8% (21)
Non-status Indian/Metis	50.0% (13)	50.0% (13)	57.7% (15)	42.3% (11)
	chi=0.73 df=1 sign.=0.39		chi=0.37 df=1 sign.=0.54	

	Want Traditional Medicines/ Healer at Clinic		Would Visit a Healer at Clinic	
	Yes	No	Yes	No
First Language Spoken				
Native	67.3% (35)	32.7% (17)	74.5% (38)	25.5% (13)
English	47.4% (18)	52.6% (20)	51.3% (20)	48.7% (19)
	chi=2.82 df=1 sign.=0.09		chi=4.23 df=1 *sign.=0.03	

	Want Traditional Medicines/ Healer at Clinic		Would Visit a Healer at Clinic	
	Yes	No	Yes	No
Languages Spoken Today				
Native/English	68.2% (45)	31.8% (21)	73.8% (48)	26.2% (17)
English only	33.3% (8)	66.7% (16)	40.0% (10)	60.0% (15)
	chi=7.44 df=1 *sign.=0.006		chi=7.61 df=1 *sign.=0.005	

	Want Traditional Medicines/ Healer at Clinic		Would Visit a Healer at Clinic	
	Yes	No	Yes	No
Mean Age	28.1 (53)	32.9 (37)	28.1 (58)	33.6 (32)
	T=-2.16 df=60 *prob.=0.03		T=-2.23 df=46 *prob.=0.03	

	Want Traditional Medicines/ Healer at Clinic		Would Visit a Healer at Clinic	
	Yes	No	Yes	No
Mean Years in City	5.8 (53)	11.0 (37)	6.4 (58)	10.3 (32)
	T=-1.82 df=40 prob.=0.07		T=-1.23 df=36 prob.=0.22	